

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PA3. Page 5 may be retained for your file.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

08130

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

08132

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>A.A.CO.</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If Institution: Residence before admission) a. STATE <u>VA.</u> b. COUNTY <u>HANOVER</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Annapolis</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>ASHLAND</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)		d. STREET ADDRESS	
3. NAME OF DECEASED (Type or print) First <u>John</u> Middle <u>Abraham</u> Last <u>S</u>		4. DATE OF DEATH Month <u>8</u> Day <u>11</u> Year <u>1957</u>	
5. SEX <u>M</u>	6. COLOR OR RACE <u>C</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>June 20, 1929</u>
9. AGE (In years last birthday) <u>27</u> yrs.		10. IF UNDER 1 YEAR Months <u>3</u> Days <u>11</u> Hours <u>37</u> Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>LABORER</u>		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) <u>HANOVER Co. VA.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>MONTAGUE ABRAMS</u>		14. MOTHER'S MAIDEN NAME <u>JULIA SHELTON</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO.	
17. INFORMANT <u>JANE ABRAMS</u>		Address <u>ASHLAND VA.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Choking</u> DUE TO <u>350X</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ (c) _____ INTERVAL BETWEEN ONSET AND DEATH <u>Instant</u>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. EXTERNAL CAUSE WAS PRIMARY OR CONTRIBUTING CAUSE OF DEATH. <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>Back turned over</u>	
20c. TIME OF INJURY Month, Day, Year Hour <u>5-11-57</u> 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>Abraham's Rm</u>		20f. (City or town) (County) (State) <u>ASHLAND</u>	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and find that death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/> .			
ACTUAL SIGNATURE <u>E. L. W. HART</u>		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type)		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
DATE SIGNED <u>8-11-57</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		22b. DATE THEREOF <u>8-16-57</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>FAMILY PLOT</u>		22d. LOCATION (City, town, or county) (State) <u>ASHLAND VA.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>DABNEY FUNERAL HOME</u>		ADDRESS <u>Box 528 ASHLAND VA</u>	
24a. REG. BY REGISTRAR		24b. REGISTRAR'S SIGNATURE <u>Wm. Adrich</u>	
DATE			

RECEIVED
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

BUREAU V. S.

AUG 13 1957

RECEIVED

08131

CERTIFICATE OF DEATH

Reg. Dist. No.

08133-1

1. PLACE OF DEATH a. COUNTY <u>Anne Arundel</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>C. C.</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Annapolis</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Annapolis</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>77 Calvert St.</u>				d. STREET ADDRESS <u>77 Calvert St.</u>			
3. NAME OF DECEASED (Type or print) <u>Charles T Adams</u>				4. DATE OF DEATH Month <u>8</u> Day <u>6</u> Year <u>1957</u>			
5. SEX <u>Male</u>		6. COLOR OR RACE <u>Col.</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>9-13-1914</u>	
9. AGE (In years last birthday) <u>42</u> yrs.		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Sales Car Driver</u>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>Annapolis, Md.</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>				13. FATHER'S NAME <u>Norman Adams</u>			
14. MOTHER'S MAIDEN NAME <u>Rosetta Madack</u>				15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, No, or unknown) <u>No</u> (If yes, give war or dates of service)			
16. SOCIAL SECURITY NO. <u>212-14-8426</u>				17. INFORMANT <u>Ada Adams - Annapolis, Md.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>410X</u> DUE TO <u>Myocardial Infarction</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Chronic Heart disease</u> DUE TO <u>1 year</u> (c)				INTERVAL BETWEEN ONSET AND DEATH			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from <u>August 1, 1956</u> to <u>August 6, 1957</u> , that I last saw the deceased alive on <u>August 2, 1957</u> , and that death occurred at <u>4:30 P.M.</u> from the causes and on the date stated above.							
ADDRESS (Street, city or town, state)				DATE SIGNED			
ACTUAL SIGNATURE <u>R. L. Richardson</u> M.D. <u>110-cty St ANNAPOLIS</u>				<u>8/7/57</u>			
PHYSICIAN'S NAME (Type)							
22a. BURIAL, CREMATION, REMOVAL (Specify)		22b. DATE THEREOF		22c. NAME OF CEMETERY OR CREMATORY		22d. LOCATION (City, town, or county) (State)	
<u>Burial</u>		<u>8-9-57</u>		<u>Brewer's Hill</u>		<u>Annapolis Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>William Reese, Jr. - Annapolis, Md.</u>				24a. REC'D BY REGISTRAR		24b. REGISTRAR'S SIGNATURE	
				<u>AUG 22 1957</u>		<u>Am. J. French</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

BUREAU V. B.

AUG 22 1957

RECEIVED

10 DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your file.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

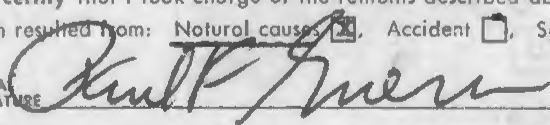
VS. A15ME(5)
SM 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

08134

Reg. Dist. No.

08169

1. PLACE OF DEATH a. COUNTY Anne Arundel MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Anne Arundel			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Glen Burnie		c. LENGTH OF STAY IN 1b		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Glen Burnie			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) 612 New Jersey Avenue				d. STREET ADDRESS 612 New Jersey Avenue		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First PAUL Middle NORBERT Last ALBRECHT				4. DATE OF DEATH Month August Day 27 Year 19 57			
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH July 7, 1957	
9. AGE (In years last birthday) 7 wks. yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS. Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)				10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Arundel Gen'l Hosp. MD. U.S.A.	
13. FATHER'S NAME Herbert Albrecht				14. MOTHER'S MAIDEN NAME Johanna Kroll			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. None		17. INFORMANT Mr. Herbert Albrecht Same As No. #2			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Bilateral Otitis Media. 391.2 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						INTERVAL BETWEEN ONSET AND DEATH	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an <u>Autopsy</u> <input checked="" type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input type="checkbox"/> , and find that death resulted from: <u>Natural causes</u> <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .							
ACTUAL SIGNATURE 				DATE SIGNED 7/27/57			
EXAMINER'S NAME (Type) Paul F. Guerin, M.D.				CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> DEPUTY MEDICAL EXAMINER <input type="checkbox"/>			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF Aug. 29, 57		22c. NAME OF CEMETERY OR CREMATORY Glen Haven Cemetery		22d. LOCATION (City, town, or county) (State) Glen Burnie, Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE R. V. Singleton				ADDRESS Glen Burnie		24a. REC'D BY REGISTRAR AUG 30 1957	
						24b. REGISTRAR'S SIGNATURE L. J. Sealbas	

206 3251 X44

MAINTAINING STATE OF MINNESOTA
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

BUREAU V. 5

AUG 30 1957

RECEIVED

Paul F. Riney

FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute this certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME
SM 2/57

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

08135

08170

Items 3/Film G220 9-18-57 et

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>ANNE ARUNDEL</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>ANNE ARUNDEL</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>DEALE BEACH</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>DEALE BEACH</u>	
c. LENGTH OF STAY IN 1b <u>4 YRS</u>		d. STREET ADDRESS <u>1</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last <u>HARRY Franklin ANDERSON JR.</u>		4. DATE OF DEATH Month Day Year <u>AUG 24 1957</u>	
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>April 27, 1953</u>
9. AGE (In years last birthday) <u>4</u> yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY <u>—</u>	
11. BIRTHPLACE (State or foreign country) <u>Annapolis, Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>HARRY ANDERSON</u>		14. MOTHER'S MAIDEN NAME <u>Ruth Estell Ward</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>		16. SOCIAL SECURITY NO. <u>—</u>	
17. INFORMANT		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>DROWNED</u> <u>929.0</u> DUE TO Conditions, if any, which gave rise to immediate cause (b) <u>—</u> (c), stating the underlying cause lost. (c) <u>—</u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>—</u> INTERVAL BETWEEN ONSET AND DEATH <u>UNKNOWN</u>			
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>FELL FROM WHARF INTO WATER</u>	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. <u>4:45 8/24/57</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>HOME</u>	20f. (City or town) (County) (State) <u>DEALE BEACH ANNE ARUNDEL MD</u>
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <u>Edward S Beck</u>		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type)		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		DATE SIGNED <u>9/6/57</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>8-27-57</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Woodfield Cem.</u>	22d. LOCATION (City, town, or county) (State) <u>Galesville, Maryland</u>
23. FUNERAL DIRECTOR'S SIGNATURE ADDRESS <u>Bernard Hardesty, Galesville, Md.</u>		24a. REC'D BY REGISTRAR DATE <u>SEP 9 57</u>	
24b. REGISTRAR'S SIGNATURE <u>Carl Smith</u>			

MEDICAL CERTIFICATION

BUREAU V. S.

SEP 9 1957

RECEIVED

CERTIFICATE OF DEATH

Reg. Dist. No.

08171

1. PLACE OF DEATH o. COUNTY Anne Arundel MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Harford	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Sherwood Forest	c. LENGTH OF STAY IN b 2 Days	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) ✓ Aberdeen 12912	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION #4 Beach Drive		d. STREET ADDRESS #452 W. Bel Air Ave.	e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First GEORGE Middle HAROLD Last BAKER		4. DATE OF DEATH Month Aug. Day 3 Year 1957	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Oct 15 1884
9. AGE (In years last birthday) 72 yrs.		IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired Canner		10b. KIND OF BUSINESS OR INDUSTRY Canner/Corn	11. BIRTHPLACE (State or foreign country) Maryland
12. CITIZEN OF WHAT COUNTRY? USA		13. FATHER'S NAME James B. Baker	
14. MOTHER'S MAIDEN NAME Frances R. Richardson		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) Yes War I.	
16. SOCIAL SECURITY NO. 216-18-7924		17. INFORMANT Address #452 W. Bel Air Mrs. Geo. Harold Baker, Sr. Aberdeen, Md	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 430.0 Probable Myocardial infarction DUE TO (b) Arteriosclerotic H.D. DUE TO (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.		INTERVAL BETWEEN ONSET AND DEATH Acute Known 8 min.	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19	20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work of work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from _____, 19____, to _____, 19____, that I last saw the deceased alive on DOA , 19____, and that death occurred at 11 P. M, from the causes and on the date stated above.			
ACTUAL SIGNATURE C. Edward Leach M.D.		ADDRESS (Street, city or town, state) 14 E. Eager St DATE SIGNED 8/4/57	
PHYSICIAN'S NAME (Type) C. EDWARD LEACH		Baltimore 2, Md	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF 8/6/1957	22c. NAME OF CEMETERY OR CREMATORY Bakers Cemetery	22d. LOCATION (City, town, or county) (State) Aberdeen, Md.
23. FUNERAL DIRECTOR'S SIGNATURE John G. [Signature] ADDRESS Baltimore, Md.		24a. REC'D BY REGISTRAR Aug 5-57	24b. REGISTRAR'S SIGNATURE [Signature]

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

BUREAU V. 4

AUG 7 1957

RECEIVED

08172

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

08137

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Anne Arundel County</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>4</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Jessup</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Baltimore 1. Md.</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Maryland House of Convalescent Hospital</u>		d. STREET ADDRESS <u>621 George St</u>	
3. NAME OF DECEASED (Type or print) First <u>Tessie</u> Middle <u>Banks</u> Last <u>Banks</u>		4. DATE OF DEATH Month <u>Aug</u> Day <u>16</u> Year <u>1957</u>	
5. SEX <u>M</u>	6. COLOR OR RACE <u>C</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>1/28-00</u>
9. AGE (In years last birthday) <u>57</u> yrs.		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Porter</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Washington C.</u>	
11. BIRTHPLACE (State or foreign country) <u>Washington C.</u>		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME <u>Andrew Banks</u>		14. MOTHER'S MAIDEN NAME <u>Lucy Johnson</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO. <u>214-36-3369</u>	
17. INFORMANT <u>Marie Banks</u> Address <u>1. 1/2</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)]			
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Arteriosclerotic Cardiovascular Disease</u>			
DUE TO			
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.			
DUE TO			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and find that death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/> .			
ACTUAL SIGNATURE <u>William H. Smith</u>		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type)		ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/>	
		DEPUTY MEDICAL EXAMINER <input type="checkbox"/>	
22a. BURIAL CREMATION REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>Aug 20/57</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>1st Auburn</u>		22d. LOCATION (City, town, or county) (State) <u>Baltimore Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Regina H. Mays</u>		24a. REC'D BY REGISTRAR <u>Aug 20 1957</u>	
ADDRESS <u>609 George St</u>		24b. REGISTRAR'S SIGNATURE <u>Clara H. Hays</u>	

THE DEPUTY MEDICAL EXAMINER: This certificate should be completed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your file. File pages 1 and 2 with the registrar. For burial, cremation, or removal.

BUREAU V. S.

1910

RECEIVED

CERTIFICATE OF DEATH

Reg. Dist. No.

08173

24

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <u>ANNE ARUNDEL</u>		MARYLAND		STATE <u>Maryland</u> COUNTY <u>Queen Anne's</u>			
CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <u>Glen Burnie</u>		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <u>Skidmore</u>		STREET ADDRESS (If rural give location)	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Plaza Manor Conv. Home</u>							
3. NAME OF DECEASED (Type or Print) <u>John W. BARNES</u>				4. DATE (Month) (Day) (Year) <u>Aug 22 1957</u>			
5. SEX <u>M</u>	6. COLOR OR RACE <u>C</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)	8. DATE OF BIRTH <u>1-29-1874</u>	9. AGE last birthday <u>86</u> yrs.	10. UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)				10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>							
13. FATHER'S NAME <u>John St. Barnes</u>				14. MOTHER'S MAIDEN NAME <u>Cissie Stonbury</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service)				16. SOCIAL SECURITY NO		17. INFORMANT & ADDRESS	
18. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH				18. MEDICAL CERTIFICATION			
IMMEDIATE CAUSE (A) <u>Arteriosclerotic heart disease</u>				INTERVAL BETWEEN ONSET AND DEATH			
ANTECEDENT CAUSE(S) DUE TO (B) <u>Arteriosclerosis general</u>							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST, DUE TO (C)							
19. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (Min.)		21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>5-17-57</u> to <u>8-22-57</u> , that I last saw the deceased alive on <u>8-1-57</u> , 19 <u>57</u> , and that death occurred at <u>11:15 A.M.</u> from the causes and on the date stated above. <u>9-22-57</u>							
SIGNATURE <u>Joseph Walter M.D. 102 Bx H Blvd. N.E. Glen Burnie Md.</u> DATE SIGNED							
23. BURIAL, CREMATION, REMOVAL (Specify)		DATE THEREOF		NAME OF CEMETERY OR CREMATORY		LOCALITY (City, town, or county) (State)	
<u>Burial</u>		<u>8-25-57</u>		<u>Broadneck</u>		<u>Skidmore Md.</u>	
24. REC'D BY REGISTRAR		REGISTRAR'S SIGNATURE		25. FUNERAL DIRECTOR'S SIGNATURE		ADDRESS	
DATE <u>5/27/57</u>		<u>Sealy</u>		<u>William H. Reese, Jr. M.D.</u>			

INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. The body may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS AISC 1-55 10M

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08132

CERTIFICATE OF DEATH

Reg. Dist. No.

21

1. PLACE OF DEATH a. COUNTY <i>Anne Arundel</i> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institutional: Residence before admission) a. STATE <i>Maryland</i> b. COUNTY <i>Al. A.</i>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Annapolis</i>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Annapolis</i>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>1029 Smithville Street</i>				d. STREET ADDRESS <i>1029 Smithville Street</i>			
3. NAME OF DECEASED (Type or print) <i>Mary Ellen</i> First Middle Last <i>Bias Bell</i>				4. DATE OF DEATH Month <i>8</i> - Day <i>31</i> Year <i>1957</i>			
5. SEX <i>Female</i>		6. COLOR OR RACE <i>Colored</i>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <i>4-3-1891</i>	
9. AGE (In years last birthday) yrs. <i>66</i>		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Housewife</i>		11. BIRTHPLACE (State or foreign country) <i>Anna Md.</i>		12. CITIZEN OF WHAT COUNTRY? <i>USA</i>	
13. FATHER'S NAME <i>Francis Bias</i>				14. MOTHER'S MAIDEN NAME <i>Mary Watkins</i>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)				16. SOCIAL SECURITY NO.		17. INFORMANT Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Sud Cent Myocardial</i> <i>431X</i> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <i>Arterial Hypertension</i> DUE TO (c) _____						INTERVAL BETWEEN ONSET AND DEATH <i>6 months</i>	
PART II: OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <i>19</i>				20d. INJURY OCCURRED While <input type="checkbox"/> at work Not while <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) (City or town) (County) (State)	
21. I certify that I attended the deceased from <i>March 15, 1957, to 8/30/57</i> , that I last saw the deceased alive on <i>8/30/57</i> , and that death occurred at <i>11:00 P.M.</i> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) <i>110-CLAY ST ANNAPOLIS, MD.</i> DATE SIGNED <i>8/3/57</i>							
ACTUAL SIGNATURE <i>R. H. Richards</i>				PHYSICIAN'S NAME (Type) _____			
22a. BURIAL, CREMATION, REMOVAL (Specify)		22b. DATE THEREOF		22c. NAME OF CEMETERY OR CREMATORY		22d. LOCATION (City, town, or county) (State)	
<i>Burial</i>		<i>2-4-57</i>		<i>Brewer Hill</i>		<i>Annapolis Md.</i>	
GENERAL DIRECTOR'S SIGNATURE <i>William J. French</i>				ADDRESS <i>Annapolis, Md.</i>		24a. REC'D BY REGISTRAR <i>EP 6</i> 24b. REGISTRAR'S SIGNATURE <i>Wm J French</i>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be signed by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

BUREAU V. S.

SEP 6 1967

RECEIVED
SEP 6 1967

Chlorine gas
leakage
at the
plant

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
08133 CERTIFICATE OF DEATH

08140
21
Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Anne Arundel</u> <u>MARYLAND</u>				2. USUAL RESIDENCE (Where deceased lived. If institutional: Residence before admission) o. STATE <u>Maryland</u> b. COUNTY <u>Anne Arundel</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Annapolis</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Severna Park</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) <u>U.S. Naval Hospital</u>				d. STREET ADDRESS <u>Manhattan Beach</u>			
3. NAME OF DECEASED (Type or print) First Middle Last <u>John</u> <u>Paige</u> <u>BENNINGTON</u>				4. DATE OF DEATH Month Day Year <u>August</u> <u>24</u> <u>1957</u>			
5. SEX <u>Male</u>	6. COLOR OR RACE <u>Caucasian</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>24 April 1900</u>		9. AGE (In years last birthday) <u>57</u> yrs	10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>U.S. Navy Retired</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>U.S. Navy</u>		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>	
13. FATHER'S NAME <u>Thomas Jefferson BENNINGTON</u>				14. MOTHER'S MAIDEN NAME <u>Marion Irene LATTARNER</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>Yes</u>		16. SOCIAL SECURITY NO. (If yes, give year or dates of service) <u>WW I WW II</u>		17. INFORMANT Address <u>U.S. Naval Hospital, Annapolis, Maryland</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebrovascular Accident</u> <u>331x</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last, (b) _____ DUE TO (c) _____ INTERVAL BETWEEN ONSET AND DEATH <u>3 months</u>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____ 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURED (Enter nature of injury in Part I or Part II of item 18)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
				20f. (City or town)		(County) (State)	
21. I certify that I attended the deceased from <u>23 May</u> , 19 <u>57</u> , to <u>24 August</u> , 19 <u>57</u> , that I last saw the deceased alive on <u>24 August</u> , 19 <u>57</u> , and that death occurred at <u>6:20 PM</u> , from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>Frederick W. Meyer, Jr.</u>				ADDRESS (Street, city or town, state) <u>U.S. Naval Hospital, Annapolis, Md.</u> DATE SIGNED <u>8-26-57</u>			
PHYSICIAN'S NAME (Type) <u>Frederick W. MEYER, Jr.</u>				Commander, Medical Corps, U.S. Navy			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>8-28-57</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Naval Academy Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Annapolis, Maryland</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Hopping Funeral Home</u>				ADDRESS <u>Annapolis, Md.</u>		24a. REC'D BY REGISTRAR <u>28 1957</u>	

BUREAU V. S.

115

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

08134

CERTIFICATE OF DEATH

08141

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Anne Arundel</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>A.A.</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Annapolis</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Crownsville</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Anne Arundel General Hosp.</u>		d. STREET ADDRESS <u>Herald Harbor</u>	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last <u>Thekla Frieda Boschen</u>		4. DATE OF DEATH Month Day Year <u>August 13 1957</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Feb. 17, 1897</u>
9. AGE (In years last birthday) <u>60</u> yrs		10. IF UNDER 1 YEAR: Months Days Hours Min <u>60</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired - Nurse</u>		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) <u>Germany</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Fritz Castens</u>		14. MOTHER'S MAIDEN NAME <u>Elizabeth Peters</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT <u>Herald Harbor</u> <u>Mr. Henry Boschen - Crownsville, Md.</u>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Peripneumonic abscess</u> DUE TO (b) <u>Acute pancreatitis</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) <u>Calculi in Common duct.</u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			INTERVAL BETWEEN ONSET AND DEATH <u>1 week</u> <u>8-10 days.</u>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town)		(County) (State)	
21. I certify that I attended the deceased from <u>2/26/57</u> , 19 <u>57</u> , to <u>8/13</u> , 19 <u>57</u> , that I last saw the deceased alive on <u>8/13/57</u> , 19 <u>57</u> , and that death occurred at <u>10:45</u> A.M., from the causes and on the date stated above ADDRESS (Street, city or town, state) DATE SIGNED <u>2. Borrows</u> M.D. <u>Amos Garrett B. Woods</u> <u>8/13/57</u> PHYSICIAN'S NAME (Type) <u>S. Borrows</u> <u>Amos Garrett B. Woods</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Cremation</u>	22b. DATE THEREOF <u>8/16/57</u>	22c. NAME OF CEMETERY OR CREMATORY <u>St. Lincoln Crematory Prince Georges Co. Md.</u>	22d. LOCATION (City, town, or county) (State)
23. FUNERAL DIRECTOR'S SIGNATURE <u>The S. H. Ainsworth</u>		24a. REC'D BY REGISTRAR <u>15 1957</u>	24b. REGISTRAR'S SIGNATURE <u>Mr. J. French</u>

BUREAU V. S.

MAY 2 1957

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

08174

CERTIFICATE OF DEATH

Reg. Dist. No.

0814224

1. PLACE OF DEATH a. COUNTY A. A. MARYLAND		2. USUAL RESIDENCE (Where deceased lived (If institution, Residence before admission) o. STATE Md. b. COUNTY A. A.	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Gibson Island		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Gibson Island	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		d. STREET ADDRESS 1	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Jeannette Middle Russell Last Baker		4. DATE OF DEATH Month August Day 25 Year 1967	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Nov. 27, 1881
9. AGE (In years lost birthday) 15 yrs.		IF UNDER 1 YEAR Months 15 Days 15 Hours 15 Min 15	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife (rtd)		10b. KIND OF BUSINESS OR INDUSTRY --	
11. BIRTHPLACE (State or foreign country) Washington, D. C.		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME Christopher E. Russell		14. MOTHER'S MAIDEN NAME Ellen Virginia -	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT Mr. W. H. Jory - Gibson Island, Md.		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) 422.1 DUE TO ACUTE PULMONARY Edema Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Arteriosclerotic cardiovascular disease DUE TO years (c)		INTERVAL BETWEEN ONSET AND DEATH 9 hrs 50 min	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o m. 19 p. m.		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from Aug 25, 1957 to Aug 25, 1957 , that I last saw the deceased alive on Aug 25, 1957 , and that death occurred at 10:50 A.M., from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED			
ACTUAL SIGNATURE William B Lyons M.D.		ADDRESS Paisley Rd. Gibson Island Md. DATE Aug 25, 1957	
PHYSICIAN'S NAME (Type) William B Lyons		ADDRESS PAISLEY RD, Gibson Island Md.	
22a. BURIAL, CREMATION, REMOVAL (Specify) Cremation		22b. DATE THEREOF 8/26/57	
22c. NAME OF CEMETERY OR CREMATORY Loudon Park Cem.		22d. LOCATION (City, town, or county) (State) Balto., Md.	
23. FUNERAL DIRECTOR'S SIGNATURE Wm. J. Dickner & Sons		24a. REC'D BY REGISTRAR Wm. J. Dickner & Sons	
ADDRESS Balto., Md.		24b. REGISTRAR'S SIGNATURE L. J. Sealey	

RECEIVED

AUG 2

BUREAU V. S.

1

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

08143

08175

CERTIFICATE OF DEATH

Reg. Dist. No. 21

1. PLACE OF DEATH

COUNTY A.A. MARYLAND
 CITY (If outside Corporate limits, write RURAL and give nearest town)
 TOWN Severn LENGTH OF STAY (in this place) Life
 HOSPITAL OR INSTITUTION OR STREET ADDRESS Box 27 - R# 2

2. USUAL RESIDENCE (HOME) OF DECEASED

STATE Maryland COUNTY A.A.
 CITY (If outside Corporate limits, write RURAL and give nearest town)
 TOWN Severn
 STREET ADDRESS (If rural give location)
Box 27, Route 2

3. NAME OF DECEASED (Type or Print)

(First) John (Middle) E. Boyer (Last) Boyer

4. DATE OF DEATH

(Month) Aug (Day) 9 (Year) 1957

5. SEX

M

6. COLOR OR RACE

W

7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)

Married

8. DATE OF BIRTH

Aug 17 1892

9. AGE last birthday

64 yrs.

IF UNDER 1 YEAR

Months Days Hours Min.

IF UNDER 24 HRS.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

Farmer

10b. KIND OF BUSINESS OR INDUSTRY

Farmer

11. BIRTHPLACE (State or foreign country)

Severn Md.

12. CITIZEN OF WHAT COUNTRY?

U.S.A.

13. FATHER'S NAME

Chas. Webster Boyer

14. MOTHER'S MAIDEN NAME

Alma Friedhepper

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.)

No

16. SOCIAL SECURITY NO.

218-12-45-11

17. INFORMANT & ADDRESS

Naomi Boyer(Wife)

18. MEDICAL CERTIFICATION

18a. IMMEDIATE CAUSE (A)

Cardio-Vascular Disease

ANTECEDENT CAUSE(S) DUE TO

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE
 STATING UNDERLYING CAUSE LAST. DUE TO

(B)

Arterio-Sclerosis

(C)

18. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.

INTERVAL BETWEEN ONSET AND DEATH

3 weeks1-3 yrs.

19a. DATE OF OPERATION

19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

YES ☐ NO ☒

21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)

21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)

21c. WHERE DID INJURY OCCUR? (City or town)

(County)

(State)

21d. TIME OF INJURY (Month) (Day) (Year)

21e. INJURY OCCURRED

While at work ☐ Not while at work ☐

21f. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 7/15/57, 1957, to 8/9/57, 1957, that I last saw the deceased alive on 8/9/57, 1957, and that death occurred at 11 P. M, from the causes and on the date stated above.

SIGNATURE

Chas. L. Ball Jr.

M.D.

L. L. Litchner

ADDRESS (Street, city, town, state)

11 P. M.

DATE SIGNED

8/9/57

23. BURIAL, CREMATION, REMOVAL (SPECIFY)

Burial

DATE THEREOF

8/12/57

NAME OF CEMETERY OR CREMATORY

Glen Haven Cemetery

LOCATION (City, town, or county)

Glen Burnie, Maryland

24. REC'D BY REGISTRAR

REGISTRAR'S SIGNATURE

L. Y. Schaefer

25. FUNERAL DIRECTOR'S SIGNATURE

Wm. J. Tuckner

ADDRESS

11 P. M.

DATE

8/12/57

INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS AISC 1-55 10M

BUREAU V. S.

AUG 1 1901

RECEIVED

08176

CERTIFICATE OF DEATH

08144

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Anne Arundel MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) b. STATE Maryland c. COUNTY Anne Arundel	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Davidsonville		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Davidsonville	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Rt 1 Box 35 A.		d. STREET ADDRESS Rt 1 Box 35 A.	
3. NAME OF DECEASED (Type or print) First BEAIR Middle McKEAN Last BROOKS		4. DATE OF DEATH Month AUGUST Day 24 , Year 19 57	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH April 3, 1896
9. AGE (in years last birthday) 61 yrs		IF UNDER 1 YEAR Months Days Hours Min	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Ret. Engineer		10b. KIND OF BUSINESS OR INDUSTRY Electrical	
11. BIRTHPLACE (State or foreign country) Suffolk, Va.		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME John Brooks		14. MOTHER'S MAIDEN NAME Louise Davis	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Yes (If yes, give war or dates of service) WW I		16. SOCIAL SECURITY NO 374 22 5918	
17. INFORMANT Mrs Helene H. Brooks, Wife		Address same as # 2	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY. IMMEDIATE CAUSE (a) arteriosclerosis 4.0.1 DUE TO Coronary Artery Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Coronary Artery DUE TO (c) Coronary Artery		INTERVAL BETWEEN ONSET AND DEATH 6 wks.	
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from Sept , 19 57 , to Aug , 19 57 , that I last saw the deceased alive on Aug 25 , 19 57 , and that death occurred at 11 , from the causes and on the date stated above. ADDRESS (Street, city or town, state) Annapolis, Md DATE SIGNED Sept 17			
ACTUAL SIGNATURE Elmer G. Linhardt M.D.		PHYSICIAN'S NAME (Type) Elmer G. Linhardt MD Annapolis, Maryland	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF August 28, 57	
22c. NAME OF CEMETERY OR CREMATORY Annapolis National Cemet		22d. LOCATION (City, town, or county) (State) Annapolis, Md	
23. FUNERAL DIRECTOR'S SIGNATURE HOPPING FUNERAL HOME		24a. REC'D BY REGISTRAR Aug 28 57	
24b. REGISTRAR'S SIGNATURE Aug 28 57			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

RECEIVED

AUG 13 1937

BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

08135

CERTIFICATE OF DEATH

08145

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Anne Arundel</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Anne Arundel</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Annapolis</u>				c. LENGTH OF STAY IN 1b <u>10</u> <u>Annapolis</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>U.S. Naval Hospital</u>				e. STREET ADDRESS <u>922 Windsor Avenue</u>			
3. NAME OF DECEASED (Type or print) First <u>William</u> Middle <u>Henry</u> Last <u>BROWN, JR.</u>				4. DATE OF DEATH Month <u>August</u> Day <u>5</u> Year <u>1957</u>			
5. SEX <u>Male</u>	6. COLOR OR RACE <u>Caucasian</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>21 June 1871</u>	9. AGE (In years last birthday) <u>86</u> yrs.	IF UNDER 1 YEAR Months <u> </u> Days <u> </u>	IF UNDER 24 HRS Hours <u> </u> Min <u> </u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>CHIEF CARPENTER MATE</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>U.S. Navy Ret.</u>		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>							
13. FATHER'S NAME <u>WILLIAM H BROWN J</u>				14. MOTHER'S MAIDEN NAME <u>MARY STALLINGS</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>Yes</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO <u> </u>		17. INFORMANT Address <u>U. S. Naval Hospital, Annapolis, Maryland</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cardiac Arrest</u> <u>420.0</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Arteriosclerosis</u> DUE TO (c) <u> </u>							INTERVAL BETWEEN ONSET AND DEATH <u> </u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u> </u>							19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. <u> </u> p. m. <u> </u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>18 May</u> , 19 <u>57</u> , to <u>5 August</u> , 19 <u>57</u> , that I last saw the deceased alive on <u>5 August</u> , 19 <u>57</u> , and that death occurred at <u>7:00 P</u> M, from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>[Signature]</u>				M.D. <u>J.S. Naval Hospital, Annapolis, Md.</u> DATE SIGNED <u>8-6-57</u>			
PHYSICIAN'S NAME (Type) <u>M. J. MILLER</u>				LT. J.C. USNR			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>Aug 8-57</u>		22c. NAME OF CEMETERY OR CREMATORY <u>St Annes Cem</u>		22d. LOCATION (City, town, or county) (State) <u>Annapolis Md</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>[Signature]</u>				ADDRESS <u>Annapolis Md.</u>		24a. REC'D BY REGISTRAR DATE <u>8/7/57</u>	
				24b. REGISTRAR'S SIGNATURE			

RECEIVED

AUG 8 1957

BUREAU V. 3

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

08177

CERTIFICATE OF DEATH

Reg. Dist. No.

08146

1. PLACE OF DEATH a. COUNTY Anne Arundel		b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Crownsville, Md.		c. LENGTH OF STAY IN b 4yrs. 1mo. 16da.		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland		b. COUNTY ↑	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Crownsville State		e. STREET ADDRESS Box 36, Sheriff Road		f. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>					
3. NAME OF DECEASED (Type or print) First Middle Last Fannie Eleanor Buckner		4. DATE OF DEATH Month Day Year 8 24 19 57		5. SEX Female		6. COLOR OR RACE Negro		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	
8. DATE OF BIRTH 3-20-1886		9. AGE (In years last birthday) 71 yrs		10. IF UNDER 1 YEAR Months Days Hours Min 71 0 0 0		11. IF UNDER 24 HRS. Months Days Hours Min 0 0 0 0		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Receipting Public Asst.		10b. KIND OF BUSINESS OR INDUSTRY -C- - - - -		11. BIRTHPLACE (State or foreign country) Virginia		12. CITIZEN OF WHAT COUNTRY? U.S.A.			
13. FATHER'S NAME John Buckner		14. MOTHER'S MAIDEN NAME Mary Elizabeth Buckner		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) - - - - -		16. SOCIAL SECURITY NO. - - - - -		17. INFORMANT Address Hospital Records Crownsville, Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cardiac Failure 450.0 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Generalized Arteriosclerosis DUE TO (c) 		INTERVAL BETWEEN ONSET AND DEATH 		PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Senility		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) 		20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 	
20f. (City or town) 		20g. (County) 		20h. (State) 		21. I certify that I attended the deceased from February, 1957 , to 8-24, 1957 , that I last saw the deceased alive on 8-24-1957 , and that death occurred at 10:25 M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) Crownsville, Md. DATE SIGNED 8-26-57			
21. SIGNATURE Lionel McHenry Mapp, M.D.		21. SIGNATURE Lionel McHenry Mapp, M.D.		21. SIGNATURE Lionel McHenry Mapp, M.D.		21. SIGNATURE Lionel McHenry Mapp, M.D.			
22a. BURIAL, CREMATION, REMOVAL (Specify) 8-28-57		22b. DATE THEREOF 8-28-57		22c. NAME OF CEMETERY OR CREMATORY Woodlawn Cemetery		22d. LOCATION (City, town, or county) Washington, D.C.		22e. (State) D.C.	
23. FUNERAL DIRECTOR'S SIGNATURE W. E. Jarvis Co. 1432 You St. N.W.		23. FUNERAL DIRECTOR'S SIGNATURE W. E. Jarvis Co. 1432 You St. N.W.		23. FUNERAL DIRECTOR'S SIGNATURE W. E. Jarvis Co. 1432 You St. N.W.		23. FUNERAL DIRECTOR'S SIGNATURE W. E. Jarvis Co. 1432 You St. N.W.		23. FUNERAL DIRECTOR'S SIGNATURE W. E. Jarvis Co. 1432 You St. N.W.	

RECEIVED

AUG 5 1957

BUREAU V. B.

08178

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No.

FOR STATE
HEALTH DEPT.

1. PLACE OF DEATH

a. COUNTY

Anne Arundel

b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)

Severn

c. LENGTH OF STAY IN 1b

Few minutes

d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)

On Old Telegraph Rd.

2. USUAL RESIDENCE (Where deceased lived If institutional Residence before admission)

a. STATE

Maryland

b. COUNTY

c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)

Baltimore

d. STREET ADDRESS

2116 W. Saratoga

e. IS RESIDENCE
ON A FARM?
YES ☐ NO ☒3. NAME OF
DECEASED

(Type or print)

S. First
Gilbert Burgess

Middle

Last

4. DATE
OF
DEATH

Month

Day

Year

August 26th.

19 57

5. SEX

M

6. COLOR OR RACE

C

7. MARRIED ☒ NEVER MARRIED ☐WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH

9/17/13

9. AGE In years
(last birthday)

63 yrs

IF UNDER 1 YEAR

Months

Days

Hours

Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

Truck Driver - U.S. Gov't-heavy duty

10b. KIND OF BUSINESS OR INDUSTRY

motor pool

11. BIRTHPLACE (State or foreign country)

Pennsylvania

12. CITIZEN OF WHAT COUNTRY?

USA

13. FATHER'S NAME

John Burgess

14. MOTHER'S MAIDEN NAME

Annie Simpson

15. WAS DECEASED EVER IN U. S. ARMED FORCES?

(Yes, no, or unknown)

(If yes, give year or dates of service)

Yes 11 World War.

16. SOCIAL SECURITY NO

193-01-2281

17. INFORMANT

Address

Mrs. G. Burgess (wife) 2116 W. Saratoga-Balt

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a)

Coronary Occlusion

420.1

DUE TO

Conditions, if any, which
gave rise to immediate cause
(a), stating the underlying
cause last.

(b)

DUE TO

(c)

INTERVAL BETWEEN
ONSET AND DEATH

Sudden

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)

19. WAS AUTOPSY
PERFORMED?
YES ☐ NO ☒20a. EXTERNAL CAUSE WAS
PRIMARY ☐ OR CONTRIBUTING ☐
CAUSE OF DEATH.

20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)

20c. TIME OF INJURY

Month, Day, Year

Hour
a. m.
p. m.

19

20d. INJURY OCCURRED

While
of work ☐ Not while
of work ☐20e. PLACE OF INJURY (Home, farm,
factory, street, office bldg., etc.)

20f. (City or town)

(County)

(State)

21. I certify that I took charge of the remains described above, held on Autopsy ☐, Inspection ☒, Inquiry ☒, and in my opinion death resulted from: Natural causes ☒, Accident ☐, Suicide ☐, Homicide ☐, Undetermined manner ☐ACTUAL
SIGNATURE

Gustave H. Faubert, M.D.

CHIEF MEDICAL EXAMINER ☐ASSISTANT MEDICAL EXAMINER ☐DEPUTY MEDICAL EXAMINER ☒

DATE SIGNED

8/26/57

22a. BURIAL, CREMATION
REMOVAL (Specify)

Burial

22b. DATE THEREOF

8-30-57

22c. NAME OF CEMETERY OR CREMATORY

Balto. National Cem.

22d. LOCATION (City, town, or county)

Balto. Md.

(State)

23. FUNERAL DIRECTOR'S SIGNATURE

ADDRESS

Samuel W. Sullivan Jr. Balto

24a. REG'D BY REGISTRAR

24b. REGISTRAR'S SIGNATURE

AUG 28 1957

Clara Kelley

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary please execute the certificate, writing the word "pending" in pencil in item 18. Give pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

RECEIVED
AUG 29 1957
BUREAU V. F.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

08179

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

Item 2
CERTIFICATE OF DEATH

08148

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Anne Arundel</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission) o. STATE <u>Maryland</u> b. COUNTY <u>Prince George's</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Crownsville</u>		c. LENGTH OF STAY IN 1b <u>2yrs. 11 days</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Crownsville State</u>		d. STREET ADDRESS <u>Cheltenham, 16 x 12</u>	
3. NAME OF DECEASED (Type or print) First <u>John</u> Middle <u>Edward</u> Last <u>Campbell</u>		4. DATE OF DEATH Month <u>8</u> Day <u>21</u> Year <u>1957</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>Negro</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>2-14-70</u>
9. AGE (In years last birthday) <u>87</u> yrs.		IF UNDER 1 YEAR Months <u> </u> Days <u> </u> Hours <u> </u> Min <u> </u>	IF UNDER 24 MRS Months <u> </u> Days <u> </u> Hours <u> </u> Min <u> </u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Porter</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>- - - - -</u>	
11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Isaac Campbell</u>		14. MOTHER'S MAIDEN NAME <u>Leila L. Campbell</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>- - - - -</u>		16. SOCIAL SECURITY NO <u>- - - - -</u>	
17. INFORMANT <u>Hospital Records</u>		Address <u>Crownsville, Maryland</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Congestive Heart Failure</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Hypertensive and Arteriosclerotic Cardio-</u> DUE TO (c) <u>vascular Disease</u>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u> </u>			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u> </u>	
20c. TIME OF INJURY Month, Day, Year Hour a. m. <u> </u> p. m. <u> </u> 19 <u>57</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u> </u>		20f. (City or town) (County) (State) <u> </u>	
21. I certify that I attended the deceased from <u>July 1, 1957</u> , to <u>August 21, 1957</u> , that I last saw the deceased alive on <u>8-21, 1957</u> , and that death occurred at <u>7:10a. M.</u> from the causes and on the date stated above. ADDRESS (Street, city or town, state) <u>Crownsville State Hospital</u> DATE SIGNED <u>8-21-57</u>			
ACTUAL SIGNATURE <u>Conwell Newton, M.D.</u> M.D. <u>Crownsville State Hospital</u>			
PHYSICIAN'S NAME (Type) <u>Conwell Newton, M. D.</u> <u>Crownsville, Maryland</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>8-27-57</u>		22b. DATE THEREOF	
22c. NAME OF CEMETERY OR CREMATORY <u>HOLY ROSARY</u>		22d. LOCATION (City, town, or county) (State) <u>PRINCE GEORGE CO.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>George Better</u>		24a. REC'D BY REGISTRAR <u>26 1957</u>	
24b. REGISTRAR'S SIGNATURE <u>K.M. Joyce</u>		24c. DATE	

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

08180

CERTIFICATE OF DEATH

08149

Reg. Dist. No.

28

1. PLACE OF DEATH a. COUNTY <u>Anne Arundel</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Crownsville State</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Baltimore</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Crownsville State</u>		d. STREET ADDRESS <u>1541 Poplar Grove Street</u>	
3. NAME OF DECEASED (Type or print) First <u>Grace</u> Middle <u>Carey</u> Last <u>Carey</u>		4. DATE OF DEATH Month <u>8</u> Day <u>21</u> Year <u>1957</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>Negro</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>unknown</u>
9. AGE (In years last birthday) <u>68?</u> yrs.		IF UNDER 1 YEAR: IF UNDER 24 HRS. Months Days Hours Min	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Cafeteria Helper</u>		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) <u>Virginia</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Thomas Carey</u>		14. MOTHER'S MAIDEN NAME -----	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. 17. INFORMANT Address <u>Hospital Records Crownsville, Md.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Hyperglycemia - Diabetic</u> <u>260x</u> DUE TO <u>Diabetes Mellitus</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) (c)			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Dehydration and Senility</u> 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. ft. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>7-11-</u> <u>1957</u> , to <u>8-21-</u> <u>1957</u> , that I last saw the deceased alive on <u>8-21-</u> <u>1957</u> , and that death occurred at <u>12:05 a.m.</u> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Lionel McHenry Mapp</u>		ADDRESS (Street, city or town, state) DATE SIGNED <u>8-21-57</u>	
PHYSICIAN'S NAME (Type) <u>Lionel McHenry Mapp, M. D.</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>25 Aug, 57</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Charlotte Co. Va</u>		22d. LOCATION (City, town, or county) (State) <u>Charlotte Co. Va</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Lester W. Dainwright</u>		24a. REC'D BY REGISTRAR DATE <u>8/23/57</u> 24b. REGISTRAR'S SIGNATURE <u>J. M. Hayes</u>	

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CERTIFICATE OF DEATH

Reg. Dist. No. **08150**
27

08181

1. PLACE OF DEATH a. COUNTY Anne Arundel b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Fort George G. Meade c. LENGTH OF STAY IN 1b 11 months d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION U. S. Army Hospital		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Anne Arundel c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Fort George G. Meade, Maryland d. STREET ADDRESS Hqs Co, 2nd USA Spt Elm e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First ROLAND Middle HOWARD Last CAREY		4. DATE OF DEATH Month Aug. Day 2 Year 19 57	
5. SEX Male	6. COLOR OR RACE Negro	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 29 April 1931 9. AGE (In years last birthday) 26 yrs.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Soldier		10b. KIND OF BUSINESS OR INDUSTRY U. S. Army	
11. BIRTHPLACE (State or foreign country) Philadelphia, Pennsylv.		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Herbert Carey		14. MOTHER'S MAIDEN NAME Lucy Fields	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) Yes		16. SOCIAL SECURITY NO 176-32-5672 1/2	
17. INFORMANT Fort Meade Personnel Records Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b) and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 9297 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Drowning ? Tentative Interim report of autopsy INTERVAL BETWEEN ONSET AND DEATH		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) Body found floating in Kelly Pool Ft Meade, Md on 2 Aug 57		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o m. p. m. ? 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) A.A.		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 1915hrs-2 Aug 57 to _____, 19____, that I last saw the deceased alive on _____, 19____, and that death occurred at _____ M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED Fort George G. Meade, Md. 2 Aug 57			
ACTUAL SIGNATURE JAMES A. CUTSHAW, Captain, MC M.D. Fort George G. Meade, Md. 2 Aug 57			
22a. DATE OF BURIAL OR CREMATION 8-6-57		22b. DATE THEREOF	
22c. NAME OF CEMETERY Beverly National		22d. LOCATION (City, town, or county) (State) Beverly, New Jersey	
23. FUNERAL DIRECTOR'S SIGNATURE Earl B. Wolverton Funeral Home, Inc ADDRESS 6306 - Belair Road, Baltimore -6, Md.		24a. REC'D BY REGISTRAR DATE 5 Aug 57	
24b. REGISTRAR'S SIGNATURE Wilbur H. Downs, Jr. Capt. MSC			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 1 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out, the funeral director, page 3, should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

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08136

CERTIFICATE OF DEATH

08151 21
Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Anne Arundel</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Anne Arundel</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Annapolis</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rural-Cape St. Clair, Annapolis</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Anne Arundel Gen. Hospital</u>		d. STREET ADDRESS e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Carmine</u> Middle <u>Raffaele</u> Last <u>Cavallo</u>		4. DATE OF DEATH Month <u>August</u> Day <u>21</u> Year <u>1957</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Oct. 26, 1887</u>
9. AGE (In years last birthday) yrs <u>69</u>		IF UNDER 1 YEAR IF UNDER 24 HRS Months Days Hours Min	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Taylor</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Homes</u>	
11. BIRTHPLACE (State or foreign country) <u>Naples Italy</u>		12. CITIZEN OF WHAT COUNTRY? <u>U. States</u>	
13. FATHER'S NAME <u>Michael Cavallo</u>		14. MOTHER'S MAIDEN NAME <u>Luigia Ratti</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO <u>216-07-1354</u>	
17. INFORMANT <u>Son, Michael - Cape St. Clair</u>		Address <u>Annapolis</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral Hemorrhage</u> 445X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Hypertensive C.V. Disease</u> DUE TO (c) <u>Generalized arteriosclerosis</u>			INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month Day Year Hour a. m. p. m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <u>1955</u> , 19____, to _____, 19____, that I last saw the deceased alive on <u>8-20</u> , 19 <u>57</u> , and that death occurred at <u>7:30</u> M, from the causes and on the date stated above ADDRESS (Street, city or town, state) DATE SIGNED <u>Robert R. Hahn, M.D. Severna Park Md</u> <u>Robert R. Hahn</u> <u>8-21-57</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>Aug. 24 1957</u>	22c. NAME OF CEMETERY OR CREMATORY <u>New Cathedral Cem.</u>
22d. LOCATION (City, town, or county) (State) <u>Baltimore Md.</u>		23. FUNERAL DIRECTOR'S SIGNATURE <u>Frank Della Noce</u> ADDRESS <u>322 S. High St</u>	
24a. REC'D BY REGISTRAR <u>8/22/57</u>		24b. REGISTRAR'S SIGNATURE <u>John J. Finch</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

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TO DEPUTY MEDICAL EXAMINER This certificate should be executed within 24 hours after death. If any delay is necessary, please enclose the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your file. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation or removal.

VS. A15ME(5)
SM 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18													
08137 MEDICAL EXAMINER'S CERTIFICATE OF DEATH					08152								
Reg. Dist. No.													
1. PLACE OF DEATH a. COUNTY <u>Anne Arundel</u> MARYLAND					2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) a. STATE <u>Maryland</u> COUNTY <u>C. C.</u>								
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Annapolis</u>			c. LENGTH OF STAY IN 1b		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Severna Park, Md.</u>			e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>A. A. General</u>					d. STREET ADDRESS <u>1</u>								
3. NAME OF DECEASED (Type or print) First <u>CLARA</u> Middle <u>COATES</u> Last <u>COATES</u>					4. DATE OF DEATH Month <u>8</u> Day <u>9</u> Year <u>1957</u>								
5. SEX <u>Female</u>		6. COLOR OR RACE <u>Col</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>6-27-1911</u>		9. AGE (In years for birthday) <u>46</u> yrs.					
10a. USUAL OCCUPATION (Give kind of work done during most of working life. If retired) <u>Domestic</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>None</u>		11. BIRTHPLACE (State or foreign country) <u>A.A. Co. Md.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>		IF UNDER 1 YEAR Months <u>0</u> Days <u>0</u> IF UNDER 24 HRS. Hours <u>0</u> Min. <u>0</u>					
13. FATHER'S NAME <u>John Summerville</u>					14. MOTHER'S MAIDEN NAME <u>Luvonia Jackson</u>								
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (If yes, give year or months of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>-</u>		17. INFORMANT Name <u>Clara Brown</u> Address <u>Severna Park, Md.</u>									
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Massive Subarachnoid Hemorrhage</u> 902.0 DUE TO Conditions, if any, which gave rise to immediate cause (b) _____ (a), stating the underlying cause last. DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTR BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____ INTERVAL BETWEEN ONSET AND DEATH _____													
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>													
20a. EXTERNAL CAUSE WAS PRIMARY OR CONTRIBUTING CAUSE OF DEATH? <input type="checkbox"/>					20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.) <u>Fell from chair to ground striking Head</u>								
20c. TIME OF INJURY Month, Day, Year <u>about 8/8/57</u>					20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>Home</u>		20f. (City or town) (County) (State) <u>Jones Station A.A.C. Md.</u>				
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and find that death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/> .													
ACTUAL SIGNATURE <u>[Signature]</u>					M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>					DATE SIGNED <u>8/10/57</u>			
EXAMINER'S NAME (Type) <u>F. L. Winkert</u>					ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>								
					DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>								
22a. BURIAL, CREMATION, REMOVAL (52-17)		22b. DATE THEREOF <u>8-13-57</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Carpenter's Hill</u>		22d. LOCATION (City, town, or county) (State) <u>Round Bay, Md.</u>							
FUNERAL DIRECTOR'S SIGNATURE <u>William Heese, Baltimore, Md.</u>					ADDRESS <u>[Address]</u>		24a. REC'D BY REGISTRAR <u>[Signature]</u>		24b. REGISTRAR'S SIGNATURE <u>[Signature]</u>				
					DATE <u>AUG 22 1957</u>								

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MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

08153

Reg. Dist.

No.

1. PLACE OF DEATH:		2. USUAL RESIDENCE (HOME) OF DECEASED:	
COUNTY <u>ANNE</u>	MARYLAND	STATE <u>VA</u>	COUNTY <u>Caroline</u>
CITY (If outside corporate limits, write RURAL OR and give nearest town) TOWN <u>Annapolis</u>	LENGTH OF STAY (in this place)	CITY (If outside corporate limits write RURAL and give nearest town) OR TOWN <u>Bally</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS		STREET ADDRESS (If rural, give location) <u>923 Wood House Court 2nd</u>	
3. NAME OF DECEASED:		4. DATE OF DEATH	
(First) <u>Fred</u>	(Middle) <u>NORMAN</u>	(Last) <u>Ch. 10/5</u>	(Month) <u>8</u> (Day) <u>11</u> (Year) <u>1957</u>
5. SEX: <u>M</u>	6. COLOR OR RACE: <u>C</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify): <u>Married</u>	8. DATE OF BIRTH: <u>Sept. 18, 1927</u>
9. AGE last birthday: <u>29</u> yrs		10. IF UNDER 1 YEAR: Months <u>8</u> Days <u>11</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of work life, even if retired): <u>Laborer</u>		10b. KIND OF BUSINESS OR INDUSTRY: <u>Brick Layer</u>	
11. BIRTHPLACE (State or foreign country): <u>Caroline Co. Va.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME: <u>Warren Childs</u>		14. MOTHER'S MAIDEN NAME: <u>Mary Elsie Washington</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service) <u>NO</u>		16. SOCIAL SECURITY No.: <u>104-11-1111</u>	
17. INFORMANT & ADDRESS: <u>Myrtle Childs, Bally Va.</u>		18. MEDICAL CERTIFICATION	
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH:		INTERVAL BETWEEN ONSET AND DEATH	
Immediate cause (a) <u>Drowning</u>		<u>Sudden</u>	
Antecedent cause(s) (b) <u>...</u>			
Diseases or conditions, if any, giving rise to the above cause (c) <u>...</u>			
stating underlying cause last			
II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.			
19a. DATE OF OPERATION:		19b. MAJOR FINDING OF OPERATION:	
20. AUTOPSY? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>			
21a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.	21b. PLACE (Home, farm, factory, street, office bldg., etc.) OF INJURY: <u>Spacious Rd</u>	21c. (City or town) <u>Anne</u>	(County) <u>...</u>
21d. TIME (Month) (Day) (Year) (Hour) OF INJURY: <u>8 11:57 AM</u>	21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>	21f. HOW DID INJURY OCCUR? <u>Back turned over</u>	
22. I hereby certify that I took charge of the remains described above held an Autopsy <input type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input type="checkbox"/> , and find that death resulted from: Natural causes <input type="checkbox"/> , Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .			
SIGNATURE: <u>John Lock</u>		M. D. <u>8-11-57</u>	
23. BURIAL, CREMATION, REMOVAL (Specify): <u>Burial</u>	DATE THEREOF: <u>...</u>	NAME OF CEMETERY OR CREMATORY: <u>St John Church</u>	LOCATION (City, town, or county) (State): <u>Caroline Co. Va.</u>
DATE REC'D BY LOCAL REG. <u>AUG 13 57</u>	REGISTRAR'S SIGNATURE: <u>...</u>	24. FUNERAL DIRECTOR: <u>DARNET FUNERAL HOME, 804 528</u>	
		ADDRESS: <u>Ashland Va.</u>	

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED

AUG 15 1937

BUREAU V. S.

CERTIFICATE OF DEATH

Reg. Dist. No 21

08139

1. PLACE OF DEATH a. COUNTY Anne Arundel MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) b. STATE Maryland c. COUNTY Anne Arundel	
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Annapolis		c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Annapolis	
d. NAME OF HOSPITAL (if not in hospital, give street address) OR INSTITUTION 104 Monticello Ave.		f. STREET ADDRESS 104 Monticello Ave.	
3. NAME OF DECEASED (Type or print) First MARIE Middle LEE Last CLARK		4. DATE OF DEATH Month August Day 31 Year 19 57	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Aug. 18, 1893
9. AGE (In years last birthday) 64 yrs		10. IF UNDER 1 YEAR Months 64 Days 0 Hours 0 Min 0	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Bookkeeper, ret		10b. KIND OF BUSINESS OR INDUSTRY Dairy Company	
11. BIRTHPLACE (State or foreign country) Edgewater, Maryland		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME William D.K. Lee		14. MOTHER'S MAIDEN NAME Mary Larrimore	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO 214-05-0660	
17. INFORMANT Leonard A. Clark		Address Son Same as # 2	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I DEATH WAS CAUSED BY IMMEDIATE CAUSE (a). 400.0 DUE TO Coronary Thrombosis Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Arteriosclerotic Heart Disease (c) 1 hr 1 month		INTERVAL BETWEEN ONSET AND DEATH 1 hr 1 month	
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Bronchiectasis, chronic			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from Sept. 1, 1955 to Aug. 30, 1957 , that I last saw the deceased alive on 8-30-1957 , and that death occurred at 7:00 P.M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) 6 Shaw Street, Annapolis, Md. DATE SIGNED 9-1-57			
ACTUAL SIGNATURE James R. Martin		M. D.	
PHYSICIAN'S NAME (Type) James R. Martin		6 Shaw Street, Annapolis, Md.	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF Sept. 4, 57	22c. NAME OF CEMETERY OR CREMATORY Cedar Bluff Cem.	22d. LOCATION (City, town, or county) (State) Annapolis, Md.
23. FUNERAL DIRECTOR'S SIGNATURE HOPPING FUNERAL HOME		ADDRESS Annapolis, Md.	
24a. REC'D BY REGISTRAR SEP 1 1957		24b. REGISTRAR'S SIGNATURE Wm. J. Funch	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4

may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed by the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

DEAN V. S.

SEP 27 1957

RECEIVED

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

08182

CERTIFICATE OF DEATH

08155

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Anne Arundel</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Baltimore City</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Crownsville</u>		c. LENGTH OF STAY IN 16 <u>4 yrs, 10 mo, 29 ds.</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Crownsville State Hospital, Md.</u>		d. STREET ADDRESS <u>101 Spring Street</u>	
3. NAME OF DECEASED (Type or print) First <u>Charlie</u> Middle <u>Coleman</u> Last <u>Coleman</u>		4. DATE OF DEATH Month <u>8</u> Day <u>16</u> Year <u>19 57</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>Negro</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Unknown</u>
9. AGE (In years last birthday) <u>67 3/4</u> yrs.		IF UNDER 1 YEAR Months <u> </u> Days <u> </u> Hours <u> </u> Min <u> </u>	IF UNDER 24 HRS Months <u> </u> Days <u> </u> Hours <u> </u> Min <u> </u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Unknown</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Unknown</u>	
11. BIRTHPLACE (State or foreign country) <u>Unknown</u>		12. CITIZEN OF WHAT COUNTRY? <u>U. S.</u>	
13. FATHER'S NAME <u>Robert Coleman</u>		14. MOTHER'S MAIDEN NAME <u>Annie</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>Unknown</u>		16. SOCIAL SECURITY NO. <u>Unknown</u>	
17. INFORMANT <u>Hospital Records</u>		Address <u>Crownsville, Md.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Tb. Lobar Pneumonia</u> DUE TO (b) <u> </u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) <u> </u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Ca. Lung</u>			INTERVAL BETWEEN ONSET AND DEATH <u>3 months</u>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month <u> </u> Day <u> </u> Year <u>19</u> Hour <u>a. m.</u> p. m. <u> </u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u> </u>	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <u>September 18, 19 52</u> , to <u>August 16, 19 57</u> , that I last saw the deceased alive on <u>August 16, 19 57</u> , and that death occurred at <u>8:45 A.</u> M., from the causes and on the date stated above. ADDRESS (Street, city or town, state) <u>Crownsville State Hospital, Md.</u> DATE SIGNED <u> </u>			
ACTUAL SIGNATURE <u>Cyril G. Hardy</u>		M.D. <u>Crownsville State Hospital, Md.</u>	
PHYSICIAN'S NAME (Type) <u>Cyril G. Hardy, M. D.</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify)	22b. DATE THEREOF <u>8-20-57</u>	22c. NAME OF CEMETERY OR CREMATORY <u>St. of Md.</u>	22d. LOCATION (City, town, or county) (State) <u>Baltimore, Md. 9/20/57</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>William Reese, Jr. - Anne, Md.</u>		24a. REC'D BY REGISTRAR <u>AUG 22 1957</u>	
ADDRESS		24b. REGISTRAR'S SIGNATURE <u>St. M. J. J.</u>	

BUREAU V. 1

JUG 22 1957

RECEIVED

INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS AISC 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

08156

Item 20 Film 219 8-23-57 ans

08183

CERTIFICATE OF DEATH

Reg. Dist. No. 27

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <u>Anne Arundel</u>		MARYLAND		STATE <u>Puerto Rico</u> COUNTY <u>---</u>			
CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <u>Fort George G. Meade</u>		LENGTH OF STAY (In this place) <u>1 yr 8 months</u>		CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <u>Carolina</u>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>U. S. Army Hospital</u> <u>U.S. ARMY HOSP FL G. G. MEADE</u>				STREET ADDRESS (If rural give location) <u>158 Munez-Rivera Street</u>			
3. NAME OF DECEASED (Type or Print) <u>LUIS</u> (First) <u>M.</u> (Middle) <u>COLON-FEBRES</u> (Last)				4. DATE (Month) (Day) (Year) OF DEATH <u>August, 12</u> 19 <u>57</u>			
5. SEX <u>Male</u>	6. COLOR OR RACE <u>Negro</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>Married</u>	8. DATE OF BIRTH <u>3 November 1935</u>	9. AGE last birthday <u>22</u> yrs.	IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Soldier</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>U. S. Army</u>		11. BIRTHPLACE (State or foreign country) <u>Puerto Rico</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Aurilio Colon-Rivera</u>				14. MOTHER'S MAIDEN NAME <u>Julia Febres-de Colon</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) <u>Yes</u> (If Yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT & ADDRESS <u>Personnel Records,</u> <u>Fort George G. Meade, Md.</u>			
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH				18. MEDICAL CERTIFICATION		INTERVAL BETWEEN ONSET AND DEATH	
X IMMEDIATE CAUSE (A) <u>Multiple lacerations of left lobe, quadrate and capsule lobe of liver with intra-abdominal hemorrhage. Laceration of right kidney.</u>							
ANTECEDENT CAUSE(S) DUE TO (B) <u>Shock</u>							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (C) <u>Compound fracture of right tibia and femur.</u>							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.) <u>Disney area, Ft. George G. Meade</u>		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State) <u>Prince George Md.</u>			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) <u>9:40 P.M. 12 Aug 57 M.</u>		21e. INJURY OCCURRED White <input type="checkbox"/> Not white <input type="checkbox"/> <u>at work</u>		21f. HOW DID INJURY OCCUR? <u>Auto accident - was in fr. it seat. was not</u>			
22. I hereby certify that I attended the deceased from <u>12 AUG 57</u> , 19 <u>57</u> , to <u>12 AUG 57</u> , 19 <u>57</u> , that I last saw the deceased alive on <u>12 AUG 57</u> , 19 <u>57</u> , and that death occurred at <u>10:20 PM</u> , from the causes and on the date stated above.							
SIGNATURE <u>John L. Robertson</u>		DATE THEREOF <u>12 Aug 57</u>		NAME OF CEMETERY OR CREMATORY <u>Municipal Cemetery</u>		LOCATION (City, town, or county) (State) <u>Carolina, Puerto Rico</u>	
23. REMOVAL		24. REC'D BY REGISTRAR <u>Wilbur H. Downs, Jr. Capt. MSC</u>		25. FUNERAL DIRECTOR'S SIGNATURE <u>Earl B. Wolverton</u>		ADDRESS <u>Funeral Home, Inc.</u> <u>6306 Belair Road, Baltimore-6, Md, USA</u>	

BUREAU V. S.

AUG 19 1957

RECEIVED

INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been filed with the registrar, the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS AISC 1-55 10M-2

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

Item 7 File #219 8-24-57 et

CERTIFICATE OF DEATH

08157

08184

Reg. Dist. No.

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <u>ALLEN ARUNDEL</u>		STATE <u>MARYLAND</u>		COUNTY <u>A.A. Co.</u>		STATE <u>MARYLAND</u>	
CITY (If outside corporate limits, write RURAL and give nearest town) <u>Ferndale, Glen Burnie</u>		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town) <u>FERDALE</u>		TOWN <u>FERDALE</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>1 Eugenia Ave</u>				STREET ADDRESS (If rural give location) <u>1 EUGENIA AVE.</u>			
3. NAME OF DECEASED (Type or Print) <u>William</u> (First) <u>CONNER</u> (Last)				4. DATE OF DEATH (Month) <u>Aug</u> (Day) <u>21</u> (Year) <u>1957</u>			
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>Married</u>	8. DATE OF BIRTH <u>Sept 7, 1892</u>	9. AGE last birthday <u>64</u> yrs.	10. UNDER 1 YEAR (Months) <u> </u> (Days) <u> </u>	11. IF UNDER 24 HRS. (Hours) <u> </u> (Min.) <u> </u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Engineering Dept Radio</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>Baltimore Md</u>		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME <u>William E Conner</u>				14. MOTHER'S MAIDEN NAME <u>Anna E Conner</u>			
15. WAS DECEASED EVER IN U S ARMED FORCES? (Yes, no, or sink) <u> </u> (If Yes, give war or dates of service) <u> </u>				16. SOCIAL SECURITY NO <u>13-6-8816</u>		17. INFORMANT & ADDRESS <u>Anna E Conner - Eugenia Ave</u>	
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH						18. MEDICAL CERTIFICATION	
18a. IMMEDIATE CAUSE (A) <u>260X</u>						INTERVAL BETWEEN ONSET AND DEATH	
18b. ANTECEDENT CAUSE(S) DUE TO <u>Arteriosclerotic heart disease</u>							
18c. DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. <u>Coronary Thrombosis</u>							
18d. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. <u>Diabetes Mellitus</u>							
19a. DATE OF OPERATION				19b. MAJOR FINDINGS OF OPERATION			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)	
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (M.)				21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?	
22. I hereby certify that I attended the deceased from <u>Feb 25</u> 19<u>57</u>, to <u>present</u> 19<u>57</u>, that I last saw the deceased alive on <u>6-1</u> 19<u>57</u>, and that death occurred at <u>2:00 P.M.</u> from the causes and on the date stated above.							
SIGNATURE <u>Joseph Taler</u>				DATE SIGNED <u>102 B&A Bldg. N.E. Glen Burnie, Md. 8-22-57</u>			
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u> </u>				DATE THEREOF <u>Aug 14-1957</u>		NAME OF CEMETERY OR CREMATORY <u>Western</u>	
24. REC'D BY REGISTRAR <u> </u>				REGISTRAR'S SIGNATURE <u> </u>		25. FUNERAL DIRECTOR'S SIGNATURE <u> </u>	
DATE <u>AUG 23 1957</u>				ADDRESS <u>1217 Shaw St</u>			

BUREAU VI B.

JUG 20 1957

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

08140

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

0815821

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY <i>A.A. Co.</i> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <i>Maryland</i> b. COUNTY <i>1</i>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Annapolis Md</i>				c. LENGTH OF STAY IN 1b			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <i>Emergency Hospital</i>				d. STREET ADDRESS <i>9323 Fourth Street</i>			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First <i>SANDRA</i> Middle <i>JEANE</i> Last <i>COOK</i>				4. DATE OF DEATH Month <i>8</i> - Day <i>17</i> Year <i>1957</i>			
5. SEX <i>F</i>		6. COLOR OR RACE <i>W</i>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <i>Feb 14, 1943</i>	
9. AGE (In years last birthday) <i>14</i> yrs.		IF UNDER 1 YEAR Months Days		IF UNDER 24 HRS. Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Student</i>				10b. KIND OF BUSINESS OR INDUSTRY <i>school</i>		11. BIRTHPLACE (State or foreign country) <i>Washington D/ C.</i>	
12. CITIZEN OF WHAT COUNTRY? <i>U S A</i>							
13. FATHER'S NAME <i>Sampson Roe Cooke</i>				14. MOTHER'S MAIDEN NAME <i>Suzanne Spindle</i>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <i>no</i>		16. SOCIAL SECURITY NO. <i>none</i>		17. INFORMANT <i>Suzanne Spindle</i> Address <i>Lanham, Maryland.</i>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>FRACURE - SKULL -</i> <i>16X</i> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) (c) DUE TO PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) INTERVAL BETWEEN ONSET AND DEATH <i>Sudden.</i>							
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18) <i>Auto accident</i>					
20c. TIME OF INJURY Month, Day, Year Hour <i>5-17</i> <i>1957</i>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <i>Highway</i>		20f. (City or town) (County) (State) <i>A.A. Co.</i>	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and find that death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/> .							
ACTUAL <i>E. Linhardt</i> EXAMINER'S NAME (Type)				M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			
DATE SIGNED <i>8-17-57</i>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>		22b. DATE THEREOF <i>Aug 20, 1957</i>		22c. NAME OF CEMETERY OR CREMATORY <i>Evergreen Cemetery</i>		22d. LOCATION (City, town, or county) (State) <i>Bladensburg, Md.</i>	
23. FUNERAL DIRECTOR'S SIGNATURE <i>Gasch's</i> ADDRESS <i>ons Hyattsville, Md.</i>				24a. REC'D BY REGISTRAR <i>AUG 22 1957</i>		24b. REGISTRAR'S SIGNATURE <i>John J. Hendricks</i>	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your file.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

BUREAU V. 3

UG 22 1957

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

08159

08185

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Anne Arundel</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Crownsville, Md.</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Baltimore</u>			
c. LENGTH OF STAY IN 1b <u>6yrs. 4mo. 13da.</u>							
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Crownsville State</u>				d. STREET ADDRESS <u>1916 Aisquith Street</u>			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First <u>David</u> Middle <u>Floyd</u> Last <u>Cooper</u>				4. DATE OF DEATH Month <u>8</u> Day <u>25</u> Year <u>1957</u>			
5. SEX <u>Male</u>		6. COLOR OR RACE <u>Negro</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>September, 1915</u>	
9. AGE (In years lost birthday) <u>42</u> yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Truck Driver</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>---</u>		11. BIRTHPLACE (State or foreign country) <u>Norfolk, Virginia</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>							
13. FATHER'S NAME <u>*****</u>				14. MOTHER'S MAIDEN NAME <u>Foster Mother - Daisy Sheffield</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)				16. SOCIAL SECURITY NO. <u>---</u>			
17. INFORMANT <u>Hospital Records</u>				Address <u>Crownsville, Maryland</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a) (b), and (c)]							
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Pneumonia</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Staphylococci Infection</u> DUE TO (c)							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>025 X</u> <u>General Paresis</u>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from <u>7-23-</u> , 1957, to <u>8-25</u> , 1957, that I last saw the deceased alive on <u>8-25</u> , 1957, and that death occurred at <u>6:45a.</u> M., from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>Conwell Newton, M.D.</u>				ADDRESS (Street, city or town, state) <u>Crownsville, Maryland</u>			
DATE SIGNED <u>8-26-57</u>							
PHYSICIAN'S NAME (Type) <u>Conwell Newton, M. D.</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify)		22b. DATE THEREOF		22c. NAME OF CEMETERY OR CREMATORY		22d. LOCATION (City, town, or county) (State)	
<u>Removal</u>		<u>8-27-57</u>		<u>Imperial City Md</u>		<u>Balt. Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>William Kneese</u>				24a. REC'D BY REGISTRAR <u>8/29/57</u>		24b. REGISTRAR'S SIGNATURE <u>J. M. Jones</u>	

RECEIVED
AUG 29 1957
BUREAU K. S.

08186

CERTIFICATE OF DEATH

Reg. Dist. No.

08160

1. PLACE OF DEATH a. COUNTY Anne Arundel MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Unknown	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Crownsville, Md.		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore City	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Crownsville State Hospital, Md.		d. STREET ADDRESS Unknown	
3. NAME OF DECEASED (Type or print) First Ruth Middle Corbin Last Corbin		4. DATE OF DEATH Month 8 Day 6 Year 1957	
5. SEX Female	6. COLOR OR RACE Negro	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Unknown
9. AGE (In years last birthday) 58 yrs.		10. IF UNDER 1 YEAR Months 58	11. IF UNDER 24 HRS. Hours 58 Min 58
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) None		10b. KIND OF BUSINESS OR INDUSTRY Unknown	
11. BIRTHPLACE (State or foreign country) Unknown		12. CITIZEN OF WHAT COUNTRY? U. S. A.	
13. FATHER'S NAME Unknown		14. MOTHER'S MAIDEN NAME Unknown	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO (If yes, give war or dates of service)	
17. INFORMANT Hospital Records		Address Crownsville, Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Heart Failure (Acute) 422.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Arteriosclerotic Cardiovascular Disease DUE TO (c) 4 to 8 years			INTERVAL BETWEEN ONSET AND DEATH sudden
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. ft. p. m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from January 28, 1920 to August 6, 1957 , that I last saw the deceased alive on August 6, 1957 , and that death occurred at M , from the causes and on the date stated above.			
ACTUAL SIGNATURE Conwell Newton, M.D.		ADDRESS (Street, city or town, state) Crownsville, Md.	
PHYSICIAN'S NAME (Type) Conwell Newton, M. D.		DATE SIGNED 8/9/57	
22a. BURIAL, CREMATION, REMOVAL (Specify)	22b. DATE THEREOF	22c. NAME OF CEMETERY OR CREMATORY Anatomy Bldg. of Md.	22d. LOCATION (City, town, or county) (State)
23. FUNERAL DIRECTOR'S SIGNATURE ADDRESS		24a. REC'D BY REGISTRAR DATE	24b. REGISTRAR'S SIGNATURE Wm. H. Reese

EURIAU A. S.

AUG

1900

08141

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>2 cc</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>MD</u> b. COUNTY <u>AA</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Annapolis</u>				c. LENGTH OF STAY IN 1b <u>20 days</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>A.A. General</u>				d. STREET ADDRESS <u>1</u>			
3. NAME OF DECEASED (Type or print) <u>LIDA ANNE</u> First Middle Last <u>Candall</u>				4. DATE OF DEATH <u>Aug</u> Month <u>3</u> Day <u>1957</u> Year			
5 SEX <u>White</u>	6. COLOR OR RACE <u>Female</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>MAY 14 1865</u>		9. AGE (In years last birthday) <u>92</u> yrs.	IF UNDER 1 YEAR Months Days Hours Min	IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>MD 40 MD.</u>		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME <u>WM. KEMP DAWSON</u>				14. MOTHER'S MAIDEN NAME <u>MARFRET REBECCA SIMMONS</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO. <u>-</u>		17. INFORMANT <u>LIDA MORELAND LOTHIAN MD</u> Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cardio-vascular accident cerebral</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>generalized arteriosclerosis</u> DUE TO (c) <u>chronic nephritis</u>							INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>July 10</u> , 1957, to <u>August 3</u> , 1957, that I last saw the deceased alive on <u>August 3</u> , 1957, and that death occurred at <u>1230</u> M., from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>Emily H. Wilson</u>				ADDRESS (Street, city or town, state) <u>Lithuan, Md</u>			
DATE SIGNED							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>8/5/57</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Luther</u>		22d. LOCATION (City, town, or county) (State) <u>Galesville Md</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Bernard Auduty</u>				ADDRESS <u>Galesville Md</u>		24a. REC'D BY REGISTRAR DATE <u>8/6/57</u>	
				24b. REGISTRAR'S SIGNATURE <u>[Signature]</u>			

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 shall be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

BUREAU V. I.

MAR 7 1957

RECEIVED

08142

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

08162

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Anne Arundel</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Anne Arundel</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Annapolis</u>				c. LENGTH OF STAY IN 1b			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>DOA Anne Arundel General Hospital</u>				e. STREET ADDRESS <u>Best Gate Rd.</u>			
3. NAME OF DECEASED (Type or print) First Middle Last <u>William Grady Dillion Jr.</u>				4. DATE OF DEATH Month Day Year <u>August 14 19 57</u>			
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>April 12, 1957</u>	9. AGE (In years last birthday) <u>4</u> yrs.	IF UNDER 1 YEAR Months Days	IF UNDER 24 HRS. Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>none</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>none</u>		11. BIRTHPLACE (State or foreign country) <u>Welch, West Virginia</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>William Grady Dillion</u>				14. MOTHER'S MAIDEN NAME <u>Josephine</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>(If yes, give war or dates of service)</u>		16. SOCIAL SECURITY NO.		17. INFORMANT <u>Mr William G. Dillion Father same as # 2</u>		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>721.0</u> DUE TO <u>Asphyxiation</u> Cardiacs, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Sudden</u> DUE TO (c)				INTERVAL BETWEEN ONSET AND DEATH			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18) <u>Aspiration Vomitus</u>					
20c. TIME OF INJURY Hour a. m. p. m. <u>19</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>Home</u>		20f. (City or town) (County) (State) <u>Lawrence NE Best Gate AA Md.</u>			
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and find that death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/> .							
ACTUAL SIGNATURE <u>Elmer G. Linhardt</u>				M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>			
EXAMINER'S NAME (Type) <u>Elmer G. Linhardt</u>				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>8-17-57</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Trinity Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Potomac, Maryland</u>	
23. FUNERARY DIRECTOR'S SIGNATURE <u>Hopping Funeral Home</u>				24a. REC'D BY REGISTRAR <u>Aug 19 1957</u>		24b. REGISTRAR'S SIGNATURE <u>Mr. J. Thers...</u>	

MEDICAL CERTIFICATION

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please enclose the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your file.
TO FUNERARY DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar for a burial, cremation, or removal.

BUREAU V. S.

AUG 19 1957

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

08163

Reg. Dist. No.

08143

1. PLACE OF DEATH a. COUNTY Anne Arundel b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Annapolis c. LENGTH OF STAY IN 1b d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Anne Arundel General Hospital		2. USUAL RESIDENCE (Where deceased lived. If institution Residence before admission) a. STATE Maryland b. COUNTY Anne Arundel c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Lothian d. STREET ADDRESS Churchton e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First HARRY Middle S Last DONALDSON	4. DATE OF DEATH Month 8th Day 16th Year 1957		
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Oct 20, 1879
9. AGE (In years last birthday) 77 yrs.		10. IF UNDER 1 YEAR IF UNDER 24 HRS Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired Capital Transit Co. Streets Cars.		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) Washington D.C.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Thomas S. Donaldson		14. MOTHER'S MAIDEN NAME Mary B.	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT Raymond A. Evans		Address 2423 Kenton Place	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Uremia 434.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Congestive failure Cardiovascular DUE TO (c) 14 days			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Cold coronary occlusion			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from August 13, 1957 to August 16, 1957 , that I last saw the deceased alive on August 16, 1957 , and that death occurred at 10:15 P.M. from the causes and on the date stated above.			
ACTUAL SIGNATURE Franklin D. Hendricks M.D.		ADDRESS (Street, city or town, state) Shady Side, Maryland	
DATE SIGNED 8/17/57			
PHYSICIAN'S NAME (Type) Franklin D. Hendricks MD			
22a. BURIAL, CREMATION, REMOVAL (Specify)	22b. DATE THEREOF 8-20-57	22c. NAME OF CEMETERY OR CRYPTORY Cedar Hill	22d. LOCATION (City, town, or county) (State) Suitland Md.
23. FUNERAL DIRECTOR'S SIGNATURE John Lee & Sons		ADDRESS 3004 E. 1st St. DC	
24a. REC'D BY REGISTRAR		24b. REGISTRAR'S SIGNATURE Thos J. French	
DATE AUG 18			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

BUREAU V. S.

AUG 19 1957

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

08187

CERTIFICATE OF DEATH

08164

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Anne Arundel MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Baltimore City	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Crownsville, Md.		c. LENGTH OF STAY IN 1b 3 yrs.	
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore City		d. STREET ADDRESS 617 N. Mount Street	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Crownville Hospital		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Anita Middle Downs Last Downs		4. DATE OF DEATH Month 8 Day 2 Year 19 57	
5. SEX Female	6. COLOR OR RACE Negro	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 6/17/1917
9. AGE (In years last birthday) 40 yrs		IF UNDER 1 YEAR Months 40 Days 0 Hours 0 Min 0	IF UNDER 24 HRS Hours 0 Min 0
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Unemployed		10b. KIND OF BUSINESS OR INDUSTRY Maryland	
11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U. S. A.	
13. FATHER'S NAME Joshua Downs		14. MOTHER'S MAIDEN NAME Susan Jackson	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Unknown		16. SOCIAL SECURITY NO Unknown	
17. INFORMANT Hospital Records		Address Crownsville, Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c.)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Bronchopneumonia 441X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Schizophrenia, Paranoid Type DUE TO (c) Schizophrenia, Paranoid Type PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Schizophrenia, Paranoid Type			INTERVAL BETWEEN ONSET AND DEATH 7/30/57
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from Oct. 27 , 19 54 , to August 2 , 19 57 , that I last saw the deceased alive on 8/2 , 19 57 , and that death occurred at 9:55 a.m. , from the causes and on the date stated above ADDRESS (Street, city or town, state) Crownsville, Md. DATE SIGNED 8/2/57 ACTUAL SIGNATURE Cornwell Newton, M.D. PHYSICIAN'S NAME (Type) Cornwell Newton, M. D.			
22a. BURIAL, CREMATION, REMOVAL (Specify)	22b. DATE THEREOF	22c. NAME OF CEMETERY OR CREMATORY	22d. LOCATION (City, town, or county) (State)
Buried	8/8/57	Int. Auburn	Baltimore Md
23. FUNERAL DIRECTOR'S SIGNATURE Marshall P. Hays		24. REC'D BY REGISTRAR DATE	24b. REGISTRAR'S SIGNATURE A. M. Jones

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1
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

08188

CERTIFICATE OF DEATH

08165

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Anne Arundel Anne Arundel Fort G. Meade		b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Fort G. Meade		c. LENGTH OF STAY IN 1b 1 day		2. USUAL RESIDENCE (Where deceased lived If institution: Residence before admission) a. STATE Ohio b. COUNTY Cincinnati, Ohio		d. STREET ADDRESS		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) KENNETH WAYNE DeChemin A Twin Boy		4. DATE OF DEATH Month Aug Day 29 Year 1957		5. SEX MALE		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 27 Aug 57 '57	
9. AGE (In years last birthday) 2 days		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) MARYLAND		12. CITIZEN OF WHAT COUNTRY? U.S.		13. FATHER'S NAME ROBERT RAY DUCHEMIN Robert DeChemin	
14. MOTHER'S MAIDEN NAME JUDITH BETH PITZER Judy		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO.		17. INFORMANT Hospital Records U.S. Army Hosp, Ft Meade, Md		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) PREMATURITY 776X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Prematurity DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH 1 day 13 hrs 25 min	
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)											
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)									
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town)		(County)		(State)	
21. I certify that I attended the deceased from _____, 19____, to _____, 19____, that I last saw the deceased alive on 29 August , 19 57 , and that death occurred at 0402 M, from the causes and on the date stated above ADDRESS (Street, city or town, state) _____ DATE SIGNED _____ ACTUAL SIGNATURE _____ M.D. C. E. Lacoste Capt MC 29 Aug 57 PHYSICIAN'S NAME (Type) C. E. LACOSTE, CAPT, MC U. S. ARMY HOS ITAL, Ft G. G. Meade, Md											
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 8-30-57		22c. NAME OF CEMETERY OR CREMATORY Baltimore, National		22d. LOCATION (City, town, or county) Baltimore, Maryland		(State)		24a. REC'D BY REGISTRAR 29 Aug 57	
23. FUNERAL DIRECTOR'S SIGNATURE Wm. COOK, Inc., 1217 St. Paul Street		24b. REGISTRAR'S SIGNATURE Robert A. [Signature]		24c. DATE 29 Aug 57		24d. TIME 11:00 AM		24e. PLACE Baltimore, Md.		24f. SIGNATURE Robert A. [Signature]	

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BUREAU V. S.

Reg. Dist. No. 27

08189

CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY <u>Anne Arundel</u>		2. USUAL RESIDENCE (Where deceased lived. If institution. Residence before admission) a. STATE <u>Ohio</u> b. COUNTY <u>Hamilton</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Fort George G. Meade</u>		c. LENGTH OF STAY IN lb <u>15 hrs 30 min</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Fort G. G. Meade U. S. Army Hospital</u>		e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Cincinnati</u>	
f. STREET ADDRESS <u>2712 Willard Avenue</u>		g. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>KEITH First WESTLEY Middle DUCHEMIN Last</u>		4. DATE OF DEATH Month <u>August</u> Day <u>28</u> Year <u>1957</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>Cau</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>August 27, 1957</u>
9. AGE (In years, last birthday) yrs <u>15</u> Months <u>3</u> Days <u>30</u> Hours <u>00</u> Min.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>None</u>	
11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Robert Ray DuChemin</u>		14. MOTHER'S MAIDEN NAME <u>Judith Beth Pitzer</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) <u>No</u>		16. SOCIAL SECURITY NO <u>None</u>	
17. INFORMANT <u>Mother, Route #1, Box 160, Crownsville, Maryland</u>		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Respiratory Failure</u> DUE TO <u>Prematurity</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last, (b) <u>Prematurity</u> DUE TO (c) _____	
19. INTERVAL BETWEEN ONSET AND DEATH <u>15 hrs 30 min</u>		20. PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____	
21. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) <input type="checkbox"/>		22. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) _____	
23. TIME OF INJURY Hour a. ft. p. m. _____ 19 _____	24. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	25. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) _____	26. (City or town) _____ (County) _____ (State) _____
27. I certify that I attended the deceased from <u>27 Aug 57</u> to <u>28 Aug 57</u> that I last saw the deceased alive on <u>27 Aug 57</u> and that death occurred at <u>7:10 M.</u> from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Arnold Fiascone</u>		DATE SIGNED <u>28 Aug 57</u>	
PHYSICIAN'S NAME (Type) <u>ARNOLD FIASCONE, Capt, MC, USAH, Ft Geo. G. Meade, Maryland</u>			
28. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	29. DATE THEREOF <u>8-29-57</u>	30. NAME OF CEMETERY OR CREMATORY <u>Baltimore National</u>	31. LOCATION (City, town, or county) (State) <u>Baltimore</u>
32. FUNERAL DIRECTOR'S SIGNATURE <u>William Cook, Inc., 1217 St. Paul Street</u>		33. REC'D BY REGISTRAR <u>Willbur H. Downs</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3, must be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

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AUG 29 1957
BUREAU W. A. 31

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please enclose the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your file.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

VS A15ME(5)
SM 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18														
08190					MEDICAL EXAMINER'S CERTIFICATE OF DEATH					08167				
										Reg. Dist. No.				
1. PLACE OF DEATH a. COUNTY <i>Inne Arundel</i> MARYLAND					2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <i>Maryland</i> b. COUNTY <i>A. A.</i>									
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Harwood</i>					c. LENGTH OF STAY IN 1b					c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Harwood</i>				
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)					d. STREET ADDRESS					e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>				
3. NAME OF DECEASED (Type or print) <i>James S. Duvall</i>					4. DATE OF DEATH Month <i>8</i> Day <i>20</i> Year <i>1957</i>									
5. SEX <i>Male</i>		6. COLOR OR RACE <i>Col</i>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <i>10-2-1902</i>		9. AGE (In years last birthday) <i>54</i> yrs.		IF UNDER 1 YEAR Months Days		IF UNDER 24 HRS. Hours Min.		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Farmer</i>					10b. KIND OF BUSINESS OR INDUSTRY <i>Self</i>					11. BIRTHPLACE (State or foreign country) <i>Maryland</i>				
12. CITIZEN OF WHAT COUNTRY? <i>U. S. A.</i>					13. FATHER'S NAME <i>Thomas Duvall</i>					14. MOTHER'S MAIDEN NAME <i>Allice Randall</i>				
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <i>No</i>					16. SOCIAL SECURITY NO (If yes, give war or dates of service) <i>—</i>					17. INFORMANT <i>Leon Duvall - Harwood, Md.</i>				
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Cardiac disease</i> <i>4343</i> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <i>Arteriosclerosis</i> DUE TO (c)										INTERVAL BETWEEN ONSET AND DEATH <i>Arteriosclerosis</i>				
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)										19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>				
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.					20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)									
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <i>10</i>					20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>					20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)				
20f. (City or town) (County) (State)														
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and find that death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/> .														
ACTUAL SIGNATURE <i>W. H. H. H.</i>					M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>					DATE SIGNED <i>8/20/57</i>				
EXAMINER'S NAME (Type) <i>W. H. H. H.</i>					ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>					DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>				
22. BURIAL, CREMATION, REMOVAL (Specify)					22b. DATE THEREOF <i>8-22-57</i>					22c. NAME OF CEMETERY OR CREMATORY <i>Brewer Hill</i>				
22d. LOCATION (City, town, or county) (State) <i>Annapolis Md.</i>					24a. REC'D BY REGISTRAR DATE <i>AUG 22 '57</i>					24b. REGISTRAR'S SIGNATURE <i>W. H. H. H.</i>				
23. FUNERAL DIRECTOR'S SIGNATURE <i>William Beebe - Annapolis, Md.</i>														

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JUG 22 1957

BUREAU V. M.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute this certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

08191

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

08168

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Anne Arundel</u> <u>MARYLAND</u>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Anne Arundel</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>P.O. Pasadena</u>		c. LENGTH OF STAY IN 1b <u>15 minutes</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Clearwater Beach, P.O. Pasadena</u>		d. STREET ADDRESS <u>8224 High Point Road</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Stoney Creek</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <u>Ferdinand</u> Middle <u>Nicholaus</u> Last <u>Ellinghaus</u>				4. DATE OF DEATH Month <u>August</u> Day <u>10th</u> Year <u>1957</u>			
5. SEX <u>Male</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>11/6/1902</u>	
9. AGE (in years last birthday) <u>54</u> yrs.		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Construction worker</u>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>Baltimore, Md.</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>				13. FATHER'S NAME <u>Henry Ellinghaus</u>			
14. MOTHER'S MAIDEN NAME <u>Elizabeth Schaum</u>				15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>			
16. SOCIAL SECURITY NO. <u>218-07-2280</u>				17. INFORMANT Address <u>Mr. Nicholas Henry Ellinghaus (brother)</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: <u>Accidental Drowning</u> IMMEDIATE CAUSE (a) <u>850x</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (b) _____ DUE TO (c) _____ INTERVAL BETWEEN ONSET AND DEATH <u>Sudden</u>							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____							
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.				20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.) <u>Was crabbing and fell off his row boat in Stoney Creek.</u>			
20c. TIME OF INJURY Month, Day, Year <u>6:30 P.M. 8/10/57</u> 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>Stoney Creek</u>		20f. (City or town) (County) (State) <u>Pasadena, A.A. Md.</u>	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and find that death resulted from: Natural causes <input type="checkbox"/> , Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .							
ACTUAL SIGNATURE <u>Gustave H. Faubert</u> M.D.				CHIEF MEDICAL EXAMINER <input type="checkbox"/>			
EXAMINER'S NAME (Type) <u>Gustave H. Faubert, M.D.</u>				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> <u>8/10/57</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>8/10/57</u>		22b. DATE THEREOF		22c. NAME OF CEMETERY OR CREMATORY <u>HOLY CROSS CEMETERY</u>		22d. LOCATION (City, town, or county) (State) <u>Baltimore</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>McCully Funeral</u>				ADDRESS			
24a. REC'D BY REGISTRAR <u>AUG 13 1957</u>		24b. REGISTRAR'S SIGNATURE <u>J. Sedberry</u>					

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JUL 1 1964
U.S. AIR FORCE

may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be kept with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

08192

Item 9

CERTIFICATE OF DEATH

0816928

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Anne Arundel MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE No Home b. COUNTY			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Crownsville				c. LENGTH OF STAY IN 1b 6 yrs.3 mos.1 da.			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Crownsville State Hospital				d. STREET ADDRESS /			
3. NAME OF DECEASED (Type or print) First Joseph Middle Evans Last Evans				4. DATE OF DEATH Month 8 Day 21 Year 19 57			
5. SEX Male	6. COLOR OR RACE Negro	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 5/25/1883		9. AGE (In years last birthday) 73 74 yrs	10. IF UNDER 1 YEAR Months 73 Days 74	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Laborer		10b. KIND OF BUSINESS OR INDUSTRY -----		11. BIRTHPLACE (State or foreign country) New Jersey		12. CITIZEN OF WHAT COUNTRY? U. S. A.	
13. FATHER'S NAME Henry Evans				14. MOTHER'S MAIDEN NAME Cathryn			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) Unknown		16. SOCIAL SECURITY NO. -----		17. INFORMANT Hospital Records Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Congestive Heart Failure DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Arteriosclerotic Heart Disease DUE TO (c)						INTERVAL BETWEEN ONSET AND DEATH Known to us since 5/10/51	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18) -----					
20c. TIME OF INJURY Month, Day, Year Hour a. m. ----- 19 p. m. -----		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) -----		20f. (City or town) (County) (State) -----	
21. I certify that I attended the deceased from 7-1 , 19 57 , to 8/21 , 19 57 , that I last saw the deceased alive on August 21 , 19 57 , and that death occurred at 11:40a M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED							
ACTUAL SIGNATURE Ernest Newton, M.D. M.D.							
PHYSICIAN'S NAME (Type)							
22a. BURIAL, CREMATION, REMOVAL (Specify) AUG-24-57		22b. DATE THEREOF		22c. NAME OF CEMETERY OR CREMATORY W.H. Anderson		22d. LOCATION (City, town, or county) (State) Baltimore 777a	
23. FUNERAL DIRECTOR'S SIGNATURE Francis H. Harnady				ADDRESS 578 W. 13th St.		24a. REC'D BY REGISTRAR DATE 8/23/57	
				24b. REGISTRAR'S SIGNATURE K. M. Jones			

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Reg. Dist. No. **08170** *4*

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY ANNE ARUNDEL MARYLAND		2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission) a. STATE MARYLAND b. COUNTY ANNE ARUNDEL	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) GLEN BURNIE		c. LENGTH OF STAY IN 1b 3 yrs	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 7 OLD STAGE ROAD		e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) GLEN BURNIE	
f. STREET ADDRESS 7 OLD STAGE ROAD		g. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) JAMES L. FISHER		4. DATE OF DEATH Month AUGUST Day 14 Year 1957	
5. SEX MALE	6. COLOR OR RACE WHITE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH JULY 10, 1989
9. AGE (In years last birthday) 68 yrs.		10. IF UNDER 1 YEAR Months 68 Days 0 Hours 0 Min. 0	
11. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) CRANE OPERATOR		12. KIND OF BUSINESS OR INDUSTRY BETH STEEL	
13. FATHER'S NAME UNKNOWN		14. MOTHER'S MAIDEN NAME UNKNOWN	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes no, or unknown) NO		16. SOCIAL SECURITY NO. (If yes, give war or dates of service) UNKNOWN	
17. INFORMATION MRS. ELLA FISHER		Address SAME	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Carcinoma of stomach 151X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) _____ DUE TO (c) _____			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from June 15, 1957 to Aug 14, 1957 , that I last saw the deceased alive on Aug 13, 1957 and that death occurred at _____, from the causes and on the date stated above. ADDRESS (Street, city or town, state) _____ DATE SIGNED _____ ACTUAL SIGNATURE Samuel Rubin M.D. 203 Catapago Ave PHYSICIAN'S NAME (Type) _____			
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		22b. DATE THEREOF AUG 17, 1957	
22c. NAME OF CEMETERY OR CREMATORY Holy ROSARY		22d. LOCATION (City, town, or county) (State) BALTIMORE, MD	
23. FUNERAL DIRECTOR'S SIGNATURE Raymond J. Stone		24a. REC'D BY REGISTRAR AUG 16	
ADDRESS 4001 Ritchie Hwy		24b. REGISTRAR'S SIGNATURE W. J. DeLoach	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the physician be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR. After this certificate has been signed by the Registrar of Attending Physicians, it may be returned by the Registrar to the funeral home.

page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper from the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

BUREAU V. S.

AUG 19 1957

RECEIVED

08144

CERTIFICATE OF DEATH

08171 21

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>A. A. Co.</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission) a. STATE <u>Id.</u> b. COUNTY <u>A. A. Co.</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Annapolis.</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Severna Park X.</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Annapolis General Hosp.</u>		d. STREET ADDRESS <u>Gordon Ave., Route 1</u>	
3. NAME OF DECEASED (Type or print) First <u>DENIS</u> Middle <u>VICTOR</u> Last <u>FORNOFF</u>		4. DATE OF DEATH Month <u>Aug.</u> Day <u>25</u> Year <u>1957</u>	
5. SEX <u>male</u>	6. COLOR OR RACE <u>white</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Aug. 17, 1957</u>
9. AGE (In years last birthday) yrs		10. IF UNDER 1 YEAR Months Days Hours Min	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>none</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Md.</u>	
11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME <u>George I. Fornoff</u>		14. MOTHER'S MAIDEN NAME <u>Madeline Donis</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>no</u>		16. SOCIAL SECURITY NO. <u>none</u>	
17. INFORMANT <u>Mr. George I. Fornoff - Gordon Ave., Route 1</u>		Address <u>Severna Park, Md.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>1167 Prematurity</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) (c)		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <u>Aug 17, 1957</u> , to <u>Aug 25, 1957</u> , that I last saw the deceased alive on <u>Aug 25, 1957</u> , and that death occurred at <u>11:00</u> M., from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED			
ACTUAL SIGNATURE <u>[Signature]</u>		M.D. <u>[Signature]</u>	
PHYSICIAN'S NAME (Type)			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>8/28/57</u>	22c. NAME OF CEMETERY OR CREMATORY <u>London Park Cem.</u>	22d. LOCATION (City, town, or county) (State) <u>Balto., Md.</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>[Signature]</u>		24. REG'D BY REGISTRAR <u>[Signature]</u>	
24b. REGISTRAR'S SIGNATURE <u>[Signature]</u>		24c. DATE <u>27 1957</u>	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

BUREAU V. S.

AUG 28 1905

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
08194 **CERTIFICATE OF DEATH**

08172

Reg. Dist. No. 21

1. PLACE OF DEATH a. COUNTY AA MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE Maryland b. COUNTY M	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Round Bay		c. LENGTH OF STAY IN 1b Yrs.	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Laurel Road		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First William Middle H. Last Gardner		4. DATE OF DEATH Month 8 Day 10 Year 1957	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Dec. 11, 1887
9. AGE (In years last birthday) yrs. 69		IF UNDER 1 YEAR Months 6 Days 10 Hours 19 Min.	IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Self Maintenance		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) Pa.		12. CITIZEN OF WHAT COUNTRY? Pa.	
13. FATHER'S NAME Fred Gardner		14. MOTHER'S MAIDEN NAME Lyda Fanning	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, No or unknown) No		16. SOCIAL SECURITY NO. 31-03 2501	
17. INFORMANT Mrs. Nelle Gardner		Address Laurel Rd.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Adenocarcinoma Prostate & Left Kidney 180X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) 2 DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) INTERVAL BETWEEN ONSET AND DEATH MAY 1, 1957 (3 months)			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19	20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from March, 1956 to August 10, 1957 , that I last saw the deceased alive on August 9, 1957 , and that death occurred at 4:30 P.M. from the causes and on the date stated above ADDRESS (Street, city or town, state) Severna Park, Md. DATE SIGNED 8/10/57 ACTUAL SIGNATURE Francis I. Codd M.D. PHYSICIAN'S NAME (Type) Francis I. Codd M.D.			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF 8/10/57	22c. NAME OF CEMETERY OR CREMATORY Jefferson Mem. Cem.	22d. LOCATION (City, town, or county) (State) McKeesport, Pa.
23. FUNERAL DIRECTOR'S SIGNATURE McOuller Funeral Home		ADDRESS 120 E. Front Ave. "20"	
24a. REC'D BY REGISTRAR AUG 12 1957		24b. REGISTRAR'S SIGNATURE Sam. J. French	

MEDICAL CERTIFICATION

THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours of death. It may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

RECEIVED
AUG 12 1957
BUREAU Y. S.

PLEASE TYPE, OR WITH PERMANENT BLACK OR BLUE-BLACK INK—DO NOT USE A BALL POINT PEN.
THIS IS A PERMANENT RECORD.

I



7. The

PLEASE TYPE, OR WITH PERMANENT BLACK OR BLUE-BLACK INK—DO NOT USE A BALL POINT PEN.
THIS IS A PERMANENT RECORD.

RECEIVED

AUG 10 1967

REAU V. S.

08174

CERTIFICATE OF DEATH

Reg. Dist. No. 21

08145

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <u>Anne Arundel</u>		STATE <u>Maryland</u>		COUNTY <u>Prince Georges</u>			
CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <u>Annapolis</u>		LENGTH OF STAY (in this place) <u>6 weeks</u>		CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <u>Bladensburg, Md.</u>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Homewood Convalescent Home</u> <u>1312 West Street</u>				STREET ADDRESS (If rural give location) <u>4103--51st Street</u>			
3. NAME OF DECEASED (Type or Print) (First) (Middle) (Last) <u>FANNIE WHEELER HAMMOND</u>				4. DATE OF DEATH (Month) (Day) (Year) <u>August 11th, 1957</u>			
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>Widowed</u>	8. DATE OF BIRTH <u>March 27th, 1871</u>	9. AGE last birthday <u>86</u> yrs.	IF UNDER 1 YEAR Months Days		IF UNDER 24 HRS. Hours Min
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>At home</u>		11. BIRTHPLACE (State or foreign country) <u>Adamstown, Md.</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Wellington Hammond</u>				14. MOTHER'S MAIDEN NAME <u>Mary E. Hilleary</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) <u>No</u>		16. SOCIAL SECURITY NO <u>None</u>		17. INFORMANT & ADDRESS <u>Wellington H. Shreve</u>			
18. MEDICAL CERTIFICATION				4103--51st St. Bladensburg, Md.			
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH				INTERVAL BETWEEN ONSET AND DEATH			
491x IMMEDIATE CAUSE (A) <u>BRONCHOPNEUMONIA</u>				<u>48 hours</u>			
ANTECEDENT CAUSE(S) DUE TO (B) <u>GENERAL DEBILITATION</u>				<u>3 mos</u>			
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST, DUE TO (C) <u>SENILITY</u>							
11 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, or INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (Min) M. <input type="checkbox"/> Not while at work <input type="checkbox"/> While at work <input type="checkbox"/>		21e. INJURY OCCURRED		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>6/25</u> , 19 <u>57</u> , to <u>8/11</u> , 19 <u>57</u> , that I last saw the deceased alive on <u>8/10</u> , 19 <u>57</u> , and that death occurred at <u>7:20 P.M.</u> from the causes and on the date stated above.							
SIGNATURE <u>Edward J. Beck</u> M.D.				ADDRESS (Street, city, town, state) <u>41 Southgate Ave Annapolis Md</u>		DATE SIGNED <u>8/11/57</u>	
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u>		DATE THEREOF <u>8/14/1957</u>		NAME OF CEMETERY OR CREMATORY <u>Mt. Olivet Cemetery</u>		LOCATION (City, town, or county) (State) <u>Frederick, Md.</u>	
24. REC'D BY REGISTRAR <u>AUG 15 1957</u>		REGISTRAR'S SIGNATURE <u>W. W. Chambers</u>		25. FUNERAL DIRECTOR'S SIGNATURE <u>W. W. Chambers Co., Riverdale, Md.</u>		ADDRESS	

INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS A15C 1-55 10M

BUREAU V. S.

AUG 15 1911

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

081754

Reg. Dist. No.

08196

1. PLACE OF DEATH a. COUNTY MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Same b. COUNTY Same			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Severna Park		c. LENGTH OF STAY IN 1b Few seconds		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Same		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Old Annapolis Road				d. STREET ADDRESS 203 Old Annapolis Rd.			
3. NAME OF DECEASED (Type or print) Frederick Gustave Henkel, IV				4. DATE OF DEATH Month August Day 12th. Year 19 57			
5. SEX M.	6. COLOR OR RACE W.	MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 8/ 1/25/43		9. AGE (In years last birthday) 14 yrs.	IF UNDER 1 YEAR Months Days 	IF UNDER 24 HRS Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Attending school		10b. KIND OF BUSINESS OR INDUSTRY 		11. BIRTHPLACE (State or foreign country) Baltimore, Md.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Frederick Gustave Henkel				14. MOTHER'S MAIDEN NAME Martha McGlannan			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. None		17. INFORMANT Address Mrs. F.G. Henkel (mother)			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Crushed skull, neck and chest. Fractures of both arms. Sudden 812 X DUE TO Conditions, if any, which gave rise to immediate cause (b) (c), stating the underlying cause last. DUE TO (c) 							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. EXTERNAL CAUSE WAS PRIMARY OR CONTRIBUTING CAUSE OF DEATH. <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) Was hit by an automobile and thrown in the path of a truck.					
20c. TIME OF INJURY Month, Day, Year Hour 3.08 o. m. 8/12/57 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Old Annapolis Rd.		20f. (City or town) Severna Park, A.A. (County) (State) Md.	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and find that death resulted from. Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/> .							
ACTUAL SIGNATURE <i>Gustave H. Faubert</i> M.D.				CHIEF MEDICAL EXAMINER <input type="checkbox"/>			
EXAMINER'S NAME (Type) Gustave H. Faubert, M.D.				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> 8/12/57			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 8/14/57		22c. NAME OF CEMETERY OR CREMATORY New Cathedral		22d. LOCATION (City, town, or county) Baltimore, Md. (State) 	
23. FUNERAL DIRECTOR'S SIGNATURE <i>H. H. ...</i>				24a. REC'D BY REGISTRAR ANG 14 1957		24b. REGISTRAR'S SIGNATURE <i>L. J. ...</i>	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please enclose the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your file.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

BUREAU V. S.

RECEIVED

SEP 5 1947

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
 TO FUNERAL HOME: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

08197

Items 1, 2, 3, 4, 5, 6, 7, 8, 9, 10, 11, 12, 13, 14, 15, 16, 17, 18, 19, 20, 21, 22, 23, 24, 25, 26, 27, 28, 29, 30, 31, 32, 33, 34, 35, 36, 37, 38, 39, 40, 41, 42, 43, 44, 45, 46, 47, 48, 49, 50, 51, 52, 53, 54, 55, 56, 57, 58, 59, 60, 61, 62, 63, 64, 65, 66, 67, 68, 69, 70, 71, 72, 73, 74, 75, 76, 77, 78, 79, 80, 81, 82, 83, 84, 85, 86, 87, 88, 89, 90, 91, 92, 93, 94, 95, 96, 97, 98, 99, 100

CERTIFICATE OF DEATH

08176

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Anne Arundel</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Anne Arundel</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Shady Side</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Shady Side</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Private home</u>				d. STREET ADDRESS <u>1</u>			
3. NAME OF DECEASED (Type or print) First <u>Ella</u> Middle <u>A.</u> Last <u>Houlton</u>				4. DATE OF DEATH Month <u>31</u> Day <u>August</u> Year <u>1957</u>			
5. SEX <u>F</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>19 Nov 1858</u>		9. AGE (In years last birthday) <u>98</u> yrs	10. IF UNDER 1 YEAR IF UNDER 24 HRS	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>House wife</u>			10b. KIND OF BUSINESS OR INDUSTRY <u>MARYLAND</u>		11. BIRTHPLACE (State or foreign country) <u>USA</u>		
13. FATHER'S NAME <u>Edward K. Houlton</u>				14. MOTHER'S MAIDEN NAME <u>Elizabeth Williams</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)				16. SOCIAL SECURITY NO		17. INFORMANT Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Tachycardia</u> DUE TO <u>Congestive failure</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Cerebral Vascular accident</u> DUE TO (c) <u>Senility</u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Senility</u> INTERVAL BETWEEN ONSET AND DEATH <u>3 days</u> <u>3 days</u> <u>3 wks.</u>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)				20g. (City or town) (County) (State)			
21. I certify that I attended the deceased from <u>Feb</u> , 19 <u>55</u> , to <u>9 Aug</u> , 19 <u>57</u> , that I last saw the deceased alive on <u>31 August</u> , 19 <u>57</u> , and that death occurred at <u>4:15 AM</u> , from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>F. D. Hendricks</u> M.D.				DATE SIGNED <u>Shady Side, Maryland 8-31-57</u>			
PHYSICIAN'S NAME (Type) <u>F. D. Hendricks</u>				ADDRESS (Street, city or town, state) <u>Shady Side, Maryland</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>9-3-57</u>		22b. DATE THEREOF		22c. NAME OF CEMETERY OR CREMATORY <u>Cedar Hill</u>		22d. LOCATION (City, town, or county) (State) <u>Switzland Md</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>The Funeral Home - L.C.</u>				ADDRESS		24a. REC'D BY REGISTRAR DATE <u>SEP 4 '57</u>	
24b. REGISTRAR'S SIGNATURE <u>Rebecca</u>							

RECEIVED

SEP 4 1962

BUREAU

may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

08198

CERTIFICATE OF DEATH

Reg. Dist. No.

0817224

1. PLACE OF DEATH a. COUNTY Annie Arundel MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission) a. STATE Maryland b. COUNTY Annie Arundel			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Glenburnie				c. LENGTH OF STAY IN 1b Life			
d. NAME OF HOSPITAL (If not in hospital give street address) OR INSTITUTION 6205 Flamingo Drive				e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Brookland, A.A.Co. Maryland			
d. NAME OF HOSPITAL (If not in hospital give street address) OR INSTITUTION 6205 Flamingo Drive				d. STREET ADDRESS 6205 Flamingo Drive			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First Middle Last James E. Howard				4. DATE OF DEATH Month Day Year August 13 1957			
5. SEX Male		6. COLOR OR RACE Colored		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH January 13, 1905	
9. AGE (In years last birthday) yrs. 52		IF UNDER 1 YEAR Months Days Hours Min		IF UNDER 24 HRS			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Inspector				10b. KIND OF BUSINESS OR INDUSTRY Industrial Plant		11. BIRTHPLACE (State or foreign country) Maryland; Annie Arundel Co.	
12. CITIZEN OF WHAT COUNTRY? U.S.A.							
13. FATHER'S NAME Solar Howard				14. MOTHER'S MAIDEN NAME Ida Howard			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No (If yes, give war or dates of service)				16. SOCIAL SECURITY NO.		17. INFORMANT Ida Howard Address Same	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Carcinoma of Intest 159x DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c)							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from May 1957 to Aug 13, 1957 , that I last saw the deceased alive on Aug 13, 1957 , and that death occurred at 10⁰⁰ M., from the causes and on the date stated above.							
ACTUAL SIGNATURE John M. Jones, Jr.				ADDRESS (Street, city or town, state) 1532 Monument St Baltimore Md			
DATE SIGNED							
PHYSICIAN'S NAME (Type)							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF Aug. 16, 1957		22c. NAME OF CEMETERY OR CREMATORY Mount Calvary Cemetery		22d. LOCATION (City, town, or county) (State) Brookland, A.A.Co. Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE Elroy C. Wilson				24. REGD BY REGISTRAR 19 1957			
24b. REGISTRAR'S SIGNATURE L. J. Hall							

BUREAU V. S.

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TO DEPUTY MEDICAL EXAMINER: This certificate should be submitted within 24 hours after death. If any delay is necessary, please excuse the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral home. Give Page 4 to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your file. DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

VS. A15ME(S)
SM 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18 08199 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

08178
Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Anne Arundel</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Anne Arundel</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Odenton</u>		c. LENGTH OF STAY IN 1b <u>2 years</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Odenton</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Patuxant Road</u>				d. STREET ADDRESS <u>Patuxant Road</u>			
3. NAME OF DECEASED (Type or print) First Middle Last <u>EVA</u> <u>JANE</u> <u>JANUARY</u>				4. DATE OF DEATH Month Day Year <u>August</u> <u>20</u> , <u>1957</u>			
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Sept. 17, 1928</u>		9. AGE (in years last birthday) <u>28</u> yrs.	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>housework</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Own Home</u>		11. BIRTHPLACE (State or foreign country) <u>West Virginia</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME (unknown) <u>Hall</u>				14. MOTHER'S MAIDEN NAME <u>Unknown</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>		16. SOCIAL SECURITY NO. <u>unknown</u>		17. INFORMANT <u>Mr. John M. January</u> Address <u>Same as #2</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Fracture of Skull due to self inflicted wound</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>a 22 gauge rifle.</u> DUE TO (c) _____ Sudden							INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>Shot herself on the forehead with a 22 gauge rifle.</u>					
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. <u>1:50</u> <u>8/20/57</u> <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>Home</u>		20f. (City or town) <u>Odenton</u> (County) <u>A.A.</u> (State) <u>MD.</u>	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and find that death resulted from: Natural causes <input type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input checked="" type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .							
ACTUAL SIGNATURE <u>Gustave H. Faubert</u>				CHIEF MEDICAL EXAMINER <input type="checkbox"/>			
EXAMINER'S NAME (Type) <u>Gustave H. Faubert M.D.</u>				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> <u>8/22/57</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>Aug. 24, 57</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Wayh Chappel Cemetery</u>		22d. LOCATION (City, town, or county) <u>Anne Arundel, Maryland</u> (State)	
23. FUNERAL DIRECTOR'S SIGNATURE <u>A. C. Singleton</u>				24. RECEIVED BY REGISTRAR <u>Aug 23 1957</u>		25. REGISTRAR'S SIGNATURE <u>Clara</u>	

BUREAU V. S.

AUG 1957

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

08146

CERTIFICATE OF DEATH

Reg. Dist. No.

08179

1. PLACE OF DEATH a. COUNTY <u>Anne Arundel</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>A.A.</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Annapolis</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Jones Station</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>A.A. General Hosp.</u>		d. STREET ADDRESS <u>Jones Station</u>	
3. NAME OF DECEASED (Type or print) <u>Baby</u> First <u>Jennings</u> Middle <u>Tennings</u> Last <u>Jennings</u>		4. DATE OF DEATH Month <u>8</u> Day <u>9</u> Year <u>1957</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>Cal.</u>	MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>8-9-57</u>
9. AGE (In years, last birthday) <u>0</u> yrs		IF UNDER 1 YEAR Months <u>0</u> Days <u>0</u> Hours <u>0</u> Min. <u>0</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>None</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>None</u>	
11. BIRTHPLACE (State or foreign country) <u>Annapolis, Md.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Shilton Jennings</u>		14. MOTHER'S MAIDEN NAME <u>Cora Dorsey</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? <u>No</u> (If yes, give year or dates of service)		16. SOCIAL SECURITY NO. <u>None</u>	
17. INFORMANT <u>Shilton Jennings - Jones, Md.</u>		Address <u>None</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>remotely</u> DUE TO <u>4711</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>None</u> DUE TO (c) <u>None</u>		INTERVAL BETWEEN ONSET AND DEATH <u>None</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. <u>19</u> p. m. <u>19</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <u>8-9-57</u> , 19 <u>57</u> , to <u>8-9-57</u> , 19 <u>57</u> , that I last saw the deceased alive on <u>8-9-57</u> , 19 <u>57</u> , and that death occurred at <u>6:30 P.M.</u> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>A.T. Allen</u>		ADDRESS (Street, city or town, state) <u>612 Cathedral St Annapolis, Md.</u>	
PHYSICIAN'S NAME (Type) <u>A.T. ALLEN</u>		DATE SIGNED <u>8-10-57</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>8-11-57</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Carpenters Hill</u>	22d. LOCATION (City, town, county) (State) <u>Sound Bay, Md.</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>William Reese, Jr. Annapolis, Md.</u>		24a. REC'D BY REGISTRAR <u>WIG 221957</u>	
ADDRESS <u>None</u>		24b. REGISTRAR'S SIGNATURE <u>W. H. French</u>	

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AUG 22 1957

BUREAU V. 31

may be retained by the hospital or attending physician.
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

08180

08200

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Anne Arundel MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission) a. STATE Md. b. COUNTY Washington	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Crownsville		c. LENGTH OF STAY IN 1b 1 yr, 2 mos, 26 ds	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Crownsville State Hospital, Md.		d. STREET ADDRESS 157 N. Jonathan Street	
3. NAME OF DECEASED (Type or print) First Middle Last Crawley Jones		4. DATE OF DEATH Month 8 Day 6 Year 1957	
5. SEX Male	6. COLOR OR RACE Negro	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 1882 ?
9. AGE (In years last birthday) 75 yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) Virginia		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME Unknown		14. MOTHER'S MAIDEN NAME Unknown	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Unknown		16. SOCIAL SECURITY NO. Hospital Records	
17. INFORMANT Address		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Acute Pulmonary Edema 430.0 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Arteriosclerotic Heart Disease DUE TO (c)	
INTERVAL BETWEEN ONSET AND DEATH 1 hour		8 months	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from May 11, 1956, to August 6, 1957, that I last saw the deceased alive on August 6, 1957, and that death occurred at 4:05 A.M. from the causes and on the date stated above.			
ACTUAL SIGNATURE Conwell Newton		ADDRESS (Street, city or town, state) DATE SIGNED	
PHYSICIAN'S NAME (Type) Conwell Newton, M. D.		22a. REC'D BY REGISTRAR	
22a. BURIAL, CREMATION, REMOVAL (Specify)		22b. DATE THEREOF	
22c. NAME OF CEMETERY OR CREMATORY Anatomy Rd. of Md.		22d. LOCATION (City, town, or county) (State)	
23. FUNERAL DIRECTOR'S SIGNATURE ADDRESS		24a. REC'D BY REGISTRAR DATE	
24b. REGISTRAR'S SIGNATURE		24c. REGISTRAR'S SIGNATURE	

MAU Y. S.

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use on the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrars prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

08181

08147

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Anne Arundel</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>A.A. Co.</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Annapolis, Md.</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Annapolis, Md.</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) <u>185 Prince George St.</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last <u>GEORGE PETER GEORGE KARANGELN</u>				4. DATE OF DEATH Month Day Year <u>August 13 1957</u>			
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>4/26/1876</u>	9. AGE (In years last birthday) <u>81</u> yrs.	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Restaurant Owner</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Restaurant</u>		11. BIRTHPLACE (State or foreign country) <u>Greece</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Unknown</u>				14. MOTHER'S MAIDEN NAME <u>Unknown</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <input type="checkbox"/>		16. SOCIAL SECURITY NO. <input type="checkbox"/>		17. INFORMANT <u>John Karangelen</u>			Address <u>Summer Rd. Annapolis, Md.</u>
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral Hemorrhage</u> <u>420.0</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Arteriosclerosis/Heart disease</u> DUE TO (c) _____						INTERVAL BETWEEN ONSET AND DEATH <u>1 month</u> <u>2 yrs.</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>Jan. 1, 1956</u> to <u>8-13, 1957</u> , that I last saw the deceased alive on <u>8-12, 1957</u> , and that death occurred at <u>12:15</u> M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) <u>6 SHAW ST. ANNAPOLIS, MD</u> DATE SIGNED <u>8-15-57</u>							
ACTUAL SIGNATURE <u>James R. Martin</u> M.D.				DATE SIGNED <u>8-15-57</u>			
PHYSICIAN'S NAME (Type) <u>JAMES R. MARTIN</u>				ADDRESS <u>ANNAPOLIS, MD</u>			
22a. BURIAL, CREMATION, or other disposal (Specify)		22b. DATE THEREOF <u>8/16/57</u>		22c. NAME OF CEMETERY OR CREMATORY <u>St. James</u>		22d. LOCATION (City, town, or county) (State) <u>Ann</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>John M. Is for and Mrs Anna olis, Md.</u>				24a. RECEIVED BY REGISTRAR DATE <u>8/16/57</u>			

BUREAU V. S.

AUG 10 1957

RECEIVED

08148

CERTIFICATE OF DEATH

Reg. Dist. No.

21

1 PLACE OF DEATH a. COUNTY <u>ANNE ARUNDEL</u> MARYLAND		2 USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>D. C.</u> b. COUNTY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>ANNAPOLIS</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>WASHINGTON 47X-3</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>ANNE ARUNDEL GEN. Hospital</u>		d. STREET ADDRESS <u>3811 S. DAKOTA-</u>	
3 NAME OF DECEASED (Type or print) First <u>JAMES</u> Middle <u>H.</u> Last <u>KELLER</u>		4 DATE OF DEATH Month <u>Aug</u> Day <u>6</u> Year <u>1957</u>	
5 SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>7-28-75</u>
9 AGE (In years birth day) <u>82</u> yrs		IF UNDER 1 YEAR Months Days Hours Min	IF UNDER 24 HRS Months Days Hours Min
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Barber</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Retired</u>	11. BIRTHPLACE (State or foreign country) <u>Pennsylvania</u>
12. CITIZEN OF WHAT COUNTRY? <u>USA</u>		13. FATHER'S NAME <u>DAVID KELLER</u>	
14. MOTHER'S MAIDEN NAME <u>Yvonne Bracken - MAREARET</u>		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)	
16. SOCIAL SECURITY NO.		17. INFORMANT Address <u>Mrs Bertha T. McCluskey - 3811 S. Dakota Ave NE Wash DC</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Myocardial Infarction</u> 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c)			INTERVAL BETWEEN ONSET AND DEATH <u>2 days -</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>41.1 Pneumonia</u>			19 WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour <u>a. m.</u> p. m. 19 <u>57</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <u>Aug 3</u> , 19 <u>57</u> , to <u>Aug 6</u> , 19 <u>57</u> , that I last saw the deceased alive on <u>Aug 6</u> , 19 <u>57</u> , and that death occurred at <u>1:05 A.M.</u> from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED			
ACTUAL SIGNATURE <u>Richard N. Peck</u> M.D.		PHYSICIAN'S NAME (Type)	
22a. BURIAL, CREMATION, REMOVAL (Specify)	22b. DATE THEREOF	22c. NAME OF CEMETERY OR CREMATORY	22d. LOCATION (City, town, or county) (State)
<u>Burial</u>	<u>8-9-57</u>	<u>Proctor Hill</u>	<u>Wash. D.C.</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>J. W. Lee Sen. Wash. D.C.</u>		24a. REC'D BY REGISTRAR DATE <u>Aug 8 1957</u>	24b. REGISTRAR'S SIGNATURE <u>Am. J. French</u>

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

RECEIVED
AUG 8 1957
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

08183

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Anne Arundel</u> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Glen Burnie</u> c. LENGTH OF STAY IN b. <u>2 months</u> d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>home of relative</u>		2. USUAL RESIDENCE (Where deceased lived If institution Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Calvert</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Dunkirk</u> d. STREET ADDRESS <u>none</u> e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Ida</u> Middle <u>Estelle</u> Last <u>King</u>		4. DATE OF DEATH Month <u>8</u> Day <u>28</u> Year <u>19 57</u>	
5. SEX <u>female</u>	6. COLOR OR RACE <u>white</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>11.26.1889</u> 9. AGE (In years last birthday) <u>67</u> yrs
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>house</u>		10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country) <u>Prine Point Md.</u> 12. CITIZEN OF WHAT COUNTRY? <u>USA</u>
13. FATHER'S NAME <u>James Stallings</u>		14. MOTHER'S MAIDEN NAME <u>Maly Crosby</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>None</u>		16. SOCIAL SECURITY NO. <u>None</u> 17. INFORMANT <u>John W. King</u> Address <u>Upper Marlboro, Md.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cardiac insufficiency</u> <u>151X</u> DUE TO <u>cancer of the stomach</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u> </u> DUE TO <u> </u> (c) <u> </u> DUE TO <u> </u>			INTERVAL BETWEEN ONSET AND DEATH <u>2 years</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u> </u>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>	20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> of work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <u>8.28</u> , 19 <u>57</u> , to <u>8.28</u> , 19 <u>57</u> , that I last saw the deceased alive on <u>8.28</u> , 9 P.M., 19 <u>57</u> , and that death occurred at <u>10.20</u> M., from the causes and on the date stated above. ADDRESS (Street, city or town, state) <u>701 Westway, Glen Burnie, Md.</u> DATE SIGNED <u>8-29-57</u>			
ACTUAL SIGNATURE <u>Andrew D. Szabo</u>		PHYSICIAN'S NAME (Type) <u>Andrew D. Szabo, I.D.</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>Aug 31, 1957</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Mt Harmony</u>	22d. LOCATION (City, town, or county) (State) <u>Mt Airy Md</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>W. H. Hutchins</u> ADDRESS <u>Quincy Md</u>		24a. REC'D BY REGISTRAR <u>8/30/57</u>	24b. REGISTRAR'S SIGNATURE <u>James F. Hutchins</u>

RECEIVED

BUREAU V. 3

SEP 17 1977

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

08184

Reg. Dist. No.

08292

1. PLACE OF DEATH a. COUNTY <u>Anne Arundel</u> MARYLAND b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Gibson Island</u> c. LENGTH OF STAY IN 1b <u>12 hrs.</u> d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>In the Bath House</u>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>A.A.</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>P.O. Pasadena</u> d. STREET ADDRESS <u>Boulevard Park</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <u>Phillip</u> First <u>W. Kurth</u> Middle Last SEX <u>M.</u> COLOR OR RACE <u>W.</u>			4. DATE OF DEATH <u>8/13/57</u> Month <u>13</u> Day <u>57</u> Year <u>19</u>				
5. SEX <u>M.</u>		6. COLOR OR RACE <u>W.</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			
8. DATE OF BIRTH <u>11/5/84</u>		9. AGE (In years and birthday) <u>72</u> yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Watchman</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Pvt Club</u>		11. BIRTHPLACE (State or foreign country) <u>Baltimore Md.</u>			
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>				13. FATHER'S NAME <u>Casper Kurth</u>			
14. MOTHER'S MAIDEN NAME <u>Unknown</u>				15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>			
16. SOCIAL SECURITY NO. <u>212-10-9186</u>		17. INFORMANT Address <u>Mrs. P.W. Kurth (wife) same as # 2</u>					
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary Occlusion</u> <u>420.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (b) _____ (c), stating the underlying cause lost. DUE TO _____ (c) _____							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.					
20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)		20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>					
20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)			
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/>, Inspection <input checked="" type="checkbox"/>, Inquiry <input checked="" type="checkbox"/>, and find that death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/>							
ACTUAL SIGNATURE <u>Gustave H. Faubert, M.D.</u>		CHIEF MEDICAL EXAMINER <input type="checkbox"/>		DATE SIGNED <u>8/15/57</u>			
EXAMINER'S NAME (Type) <u>Gustave H. Faubert, M.D.</u>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>		DEPUTY MEDICAL EXAMINER <input type="checkbox"/>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>Aug 16, 57</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Glen Haven Cemetery Glen Burnie, Md.</u>			
22d. LOCATION (City, town, or county) (State)		23. FUNERAL DIRECTOR'S SIGNATURE AND ADDRESS <u>HOPPING AND KIRKLEY</u> <u>Glen Burnie, Md.</u>					
24a. REC'D BY REGISTRAR		24b. REGISTRAR'S SIGNATURE <u>[Signature]</u>					

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please enclose the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral home. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar for burial, cremation, or removal.

BUREAU Y. R.

JUG 16 1957

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

08203

CERTIFICATE OF DEATH

08185 *24*
Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Anne Arundel</u>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Anne Arundel</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Glen Burnie</u>			c. LENGTH OF STAY IN 1b <u>28 yrs.</u>			c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Glen Burnie</u> <u>X</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>#2 Oak Lane, S.W.</u>				d. STREET ADDRESS <u>#2 Oak Lane S.W.</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>CHARLES</u> Middle <u>MARSHAL</u> Last <u>LAKE</u>				4. DATE OF DEATH Month <u>August</u> Day <u>1</u> Year <u>1957</u>			
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Jan. 24, 1884</u>		9. AGE (In years last birthday) <u>73</u> yrs.	IF UNDER 1 YEAR Months Days Hours Min	IF UNDER 24 HRS
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Realtor (ret.)</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Self-Employed</u>		11. BIRTHPLACE (State or foreign country) <u>Virginia</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Charles R. Lake</u>			14. MOTHER'S MAIDEN NAME <u>Florence V. Rixey</u>				
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>		16. SOCIAL SECURITY NO. <u>212-07-4104</u>		17. INFORMANT <u>Mrs. Pauline S. Lake</u>		Address <u>Same As #2</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Acute Coronary Occlusion</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Cardio-Vascular Disease</u> DUE TO (c) _____ INTERVAL BETWEEN ONSET AND DEATH <u>5 min.</u> <u>10 yrs.</u>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____ 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Hour _____ a. m. _____ p. m. _____ Month _____ Day _____ Year <u>19</u>	20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) _____ (County) _____ (State) _____		
21. I certify that I attended the deceased from <u>March</u> , 19 <u>47</u> , to <u>Aug.</u> , 19 <u>57</u> , that I last saw the deceased alive on <u>July 31</u> , 19 <u>57</u> , and that death occurred at <u>1:50</u> <u>A</u> .M., from the causes and on the date stated above. ADDRESS (Street, city or town, state) _____ DATE SIGNED <u>8/2/57</u>							
ACTUAL SIGNATURE <u>James S. Billingslea</u> M.D.				DATE SIGNED <u>8/2/57</u>			
PHYSICIAN'S NAME (Type) <u>James S. Billingslea</u>				<u>108 Central Ave., Glen Burnie, Md.</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>Aug. 5, 1957</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Cedar Hill Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Broadway, RED, Maryland</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>[Signature]</u>				ADDRESS <u>Glen Burnie, Md.</u>		24. REGISTRAR'S SIGNATURE <u>[Signature]</u>	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

RECEIVED

1957

BUREAU V. S.

CERTIFICATE OF DEATH

Reg. Dist. No

C8204

1 PLACE OF DEATH a. COUNTY ATLIE ARUNDEL, MD MARYLAND				2 USUAL RESIDENCE (Where deceased lived If institution: Residence before admission) a. STATE MD b. COUNTY BALTIMORE			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) FORT GEORGE G MEADE				c. LENGTH OF STAY IN 1b 29 DAYS			
d. NAME OF HOSPITAL (If not in hospital, give street address) US ARMY HOSPITAL				d. STREET ADDRESS 7103 DUNMAN WAY			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First Middle Last EDNA M MARTIN				4. DATE OF DEATH Month Day Year AUG 17 1957			
5. SEX FEMALE	6. COLOR OR RACE CAU	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 9 JUL 1898	9. AGE (In years last birthday) 59 yrs.	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSEWIFE		10b. KIND OF BUSINESS OR INDUSTRY AT HOME		11. BIRTHPLACE (State or foreign country) BALTO		12. CITIZEN OF WHAT COUNTRY? US	
13. FATHER'S NAME FLETCHER J SHECKELS				14. MOTHER'S MAIDEN NAME MARY F WATERS			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT FRANK C MARTIN 7103 DUNMAN WAY BALTO, MD			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) PULMONARY EDEMA 260X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) ASHD WITH CONGESTED FAILURE AND ASCITIS DUE TO (c) DIABETES MELLITUS WITH NEPHROSIS AND EARLY UREMIA						INTERVAL BETWEEN ONSET AND DEATH 12 HRS. 2 MONS 17 YRS.	
PART II OTHER SIGNIFICANT CONDITIONS CONTR BUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month Day Year Hour a. m. p. m. 19	20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town)	(County)	(State)		
21. I certify that I attended the deceased from 20 JULY 1957 to 17 AUG 1957 , that I last saw the deceased alive on 17 AUG 1957 , and that death occurred at 1200 P.M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED							
ACTUAL SIGNATURE <i>[Signature]</i>		M.D. USA HOSPITAL FT. GEORGE G MEADE 17 AUG 57					
NAME (Type) JOHN G ROBERTSON CAPT. MD.		USA HOSPITAL FORT GEORGE G MEADE 17 AUG 57					
22a. BURIAL, CREMATION, REMOVAL (Specify)	22b. DATE THEREOF Aug 20, 1957	22c. NAME OF CEMETERY OR CREMATORY Baltimore National	22d. LOCATION (City, town or county)	(State) MD			
23. FUNERAL DIRECTOR'S SIGNATURE <i>[Signature]</i> ADDRESS Howard Evans - 5a. Charles St			24a. REC'D BY REGISTRAR DATE AUG 20 57	24b. REGISTRAR'S SIGNATURE <i>[Signature]</i>			

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

RECEIVED

NOV 19 1967

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

08187

08205

Reg. Dist. No. **27**

1. PLACE OF DEATH a. COUNTY Anne Arundel b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Odenton c. LENGTH OF STAY IN 1b 2 years d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) 207 Monterey Avenue				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Same b. COUNTY Same c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Same d. STREET ADDRESS Same e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First HAROLD Middle M. Last MCNAMARA				4. DATE OF DEATH Month August Day 6 Year 1957			
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH April 3, 1905	
9. AGE (In years last birthday) 52 yrs.		10. IF UNDER 1 YEAR Months 2 Days 2 Hours 2 Min.		11. BIRTHPLACE (State or foreign country) York, Pennsylvania		12. CITIZEN OF WHAT COUNTRY? USA	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Professional Dancer				10b. KIND OF BUSINESS OR INDUSTRY —			
13. FATHER'S NAME Thomas McNamara				14. MOTHER'S MAIDEN NAME Helen O'Brien			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Yes		16. SOCIAL SECURITY NO. World War 2		17. INFORMANT Mrs. Dennis Dell (Sister) Address Odenton, Md			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary Thrombosis DUE TO (b) 420.1 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c) —							INTERVAL BETWEEN ONSET AND DEATH 3 hours
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a):							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)					
20c. TIME OF INJURY Hour 19 o. m. — p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and find that death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/> .							
ACTUAL SIGNATURE Gustave H. Faubert				M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>		DATE SIGNED August 6, 1957	
EXAMINER'S NAME (Type) Gustave H. Faubert, M.D.				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify)		22b. DATE THEREOF 8/9/57		22c. NAME OF CEMETERY OR CREMATORY Mt. Olivet		22d. LOCATION (City, town, or county) (State) Hammer Pa York Co	
23. FUNERAL DIRECTOR'S SIGNATURE Frederick Buckner Hammer Co				ADDRESS —		24a. REC'D BY REGISTRAR — DATE 6 Aug 57	
				24b. REGISTRAR'S SIGNATURE Wilbur H. Downs, Jr. Capt. M.S.C.			

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please enclose the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files. Fill in pages 1 and 2 with the registrar's permit. Fill in pages 1 and 2 with the registrar's permit to burial, cremation, or removal.

RECEIVED
AUG 12 1957
BUREAU V. S.

08149

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Anne Arundel</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Anne Arundel</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Annapolis</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Annapolis</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>U.S. Naval Hospital</u>				d. STREET ADDRESS <u>Apt. 1102 Dream's Landing</u>			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First <u>Joan</u> Middle <u>Ann</u> Last <u>MODE</u>				4. DATE OF DEATH Month <u>August</u> Day <u>21</u> Year <u>1957</u>			
5. SEX <u>Female</u>		6. COLOR OR RACE <u>Caucasian</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>21 August 1957</u>	
9. AGE (In years last birthday) yrs.		IF UNDER 1 YEAR Months		IF UNDER 24 HRS Days		Hours	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>	
13. FATHER'S NAME <u>Paul Joseph MODE</u>				14. MOTHER'S MAIDEN NAME <u>Clair A. BROWSKE</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. (If yes, give war or dates of service)		17. INFORMANT <u>U.S. Naval Hospital, Annapolis, Maryland</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Prematurity</u> DUE TO (b) <u>Immaturity</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c)		INTERVAL BETWEEN ONSET AND DEATH <u>40 min</u>		PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>21 August</u> , 19 <u>57</u> , to <u>21 August</u> , 19 <u>57</u> , that I last saw the deceased alive on <u>21 August</u> , 19 <u>57</u> , and that death occurred at <u>7:35A.</u> M, from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>Richard D. Sheehan</u> M.D.				ADDRESS (Street, city or town, state) <u>U.S. Naval Hospital, Annapolis, Md.</u>			
DATE SIGNED <u>8-21-57</u>							
PHYSICIAN'S NAME (Type) <u>Richard D. SHEEHAN</u> <u>Lieutenant, Medical Corps, U. S. Navy</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>8-22-57</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Naval Academy</u>		22d. LOCATION (City, town, or county) (State) <u>Annapolis Md</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>John M. Taylor Srs</u>				ADDRESS <u>Annapolis Md</u>		24a. REC'D BY REGISTRAR <u>8/22/57</u>	
24b. REGISTRAR'S SIGNATURE <u>O. D. D. D.</u>							

RECEIVED

AUG 28 1957

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

08206

CERTIFICATE OF DEATH

08189 28

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Anne Arundel</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution. Residence before admission) a. STATE <u>Maryland</u> b. COUNTY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Crownsville, Md.</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Baltimore</u> 37014	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Crownsville State</u>		d. STREET ADDRESS <u>Unknown</u>	
3. NAME OF DECEASED (Type or print) First <u>Robert</u> Middle <u>Lee</u> Last <u>Moreland</u>		4. DATE OF DEATH Month <u>8</u> Day <u>27</u> Year <u>19 57</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>Negro</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> Sep. DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>6-13-1889</u>
9. AGE (In years last birthday) <u>68</u> yrs.		IF UNDER 1 YEAR Months <u>-</u> Days <u>-</u> Hours <u>-</u> Min. <u>-</u>	IF UNDER 24 HRS. Months <u>-</u> Days <u>-</u> Hours <u>-</u> Min. <u>-</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Unknown</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>- - - - -</u>	
11. BIRTHPLACE (State or foreign country) <u>Ohio</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Thomas Moreland</u>		14. MOTHER'S MAIDEN NAME <u>Jane Moreland</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>- - - - -</u>		16. SOCIAL SECURITY NO. <u>- - - - -</u>	
17. INFORMANT <u>Hospital Records</u>		Address <u>Crownsville, Md.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)]			
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Congestive Heart Failure</u>			
420.0 DUE TO			
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.			
(b) <u>Arteriosclerotic Heart Disease</u>			
DUE TO			
(c)			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
<u>Arteriosclerotic Brain Syndrome - Bilateral Inguinal Hernia</u>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour <u>a. m.</u> <u>19</u> p. m.		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>6-13-57</u> , 19 <u>57</u> , to <u>8-27-</u> , 19 <u>57</u> , that I last saw the deceased alive on <u>8-27-</u> , 19 <u>57</u> , and that death occurred at <u>8:10 a.m.</u> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) <u>Crownsville, Maryland</u> DATE SIGNED <u>8-27-57</u>			
ACTUAL SIGNATURE <u>Lionel McHenry Mapp</u>		M.D. <u>Crownsville, Maryland</u>	
PHYSICIAN'S NAME (Type) <u>Lionel McHenry Mapp, M. D.</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify)	22b. DATE THEREOF	22c. NAME OF CEMETERY OR CREMATORY	22d. LOCATION (City, town, or county) (State)
<u>Burial</u>	<u>8-29-57</u>	<u>St. Mary's Cemetery</u>	<u>St. Mary's</u>
23. FUNERAL DIRECTOR'S SIGNATURE		ADDRESS	24a. REC'D BY REGISTRAR
<u>Lionel McHenry Mapp</u>		<u>1051 North ...</u>	DATE <u>8/30/57</u>
		24b. REGISTRAR'S SIGNATURE <u>X. M. Joyce</u>	

BUREAU V. B.

SEP 3 1957

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

08150

CERTIFICATE OF DEATH

08190

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>AA</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived If institution; Residence before admission) a. STATE <u>Md.</u> b. COUNTY <u>AA</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Annapolis</u>		c. LENGTH OF STAY IN 1b <u>Fishing Creek Farm R F D. R.</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>General</u>		d. STREET ADDRESS <u>Annapolis Md.</u>	
3. NAME OF DECEASED (Type or print) First <u>JOHN</u> Middle <u>MURCHAKE</u> Last <u>MURCHAKE</u>		4. DATE OF DEATH Month <u>8</u> Day <u>29</u> Year <u>1957</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>July 27th 1898</u>
9. AGE (In years last birthday) <u>39</u> yrs.		10. IF UNDER 1 YEAR: Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u>	
11. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Mill Foreman</u>		12. KIND OF BUSINESS OR INDUSTRY <u>Lumber Yard</u>	
13. BIRTHPLACE (State or foreign country) <u>Bridgeport Conn</u>		14. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>	
15. FATHER'S NAME <u>Michael Murchake</u>		16. MOTHER'S MAIDEN NAME <u>Unknown</u>	
17. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u> </u> (If yes, give war or dates of service) <u> </u>		18. SOCIAL SECURITY NO. <u> </u>	
19. INFORMANT <u>Mary Ann Murchake</u>		Address <u>(2)</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>CORONARY THROMBOSIS</u> 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. <u>260X</u> (b) <u>ARTERIOSCLEROTIC CORONARY ARTERY DIS.</u> DUE TO (c) <u>ARTERIOSCLEROTIC CARDIO-VASC. DIS</u>		INTERVAL BETWEEN ONSET AND DEATH <u>12 HRS</u> <u>16 YRS</u> <u>UNKNOWN</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>DIABETES MELLITUS</u>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. <u> </u> p. m. <u> </u> 19 <u> </u>		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>MAY, 1955</u> to <u>29 AUG., 1957</u> , that I last saw the deceased alive on <u>29 AUG., 1957</u> , and that death occurred at <u>7:45 P.M.</u> , from the causes and on the date stated above			
ACTUAL SIGNATURE <u>Edward S. Beck</u> M.D.		ADDRESS (Street, city or town, state) DATE SIGNED <u>8/30/57</u>	
PHYSICIAN'S NAME (Type) <u>EDWARD S. BECK</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u> </u>		22b. DATE THEREOF <u>9-6-57</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>HILLCREST</u>		22d. LOCATION (City, town, or county) (State) <u> </u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>John M. Taylor</u>		24a. RECEIVED BY REGISTRAR <u> </u> 24b. REGISTRAR'S SIGNATURE <u> </u>	
ADDRESS <u>Annapolis, Md.</u>		DATE <u>9/3/57</u>	

RECEIVED

SEP 7

RECEIVED

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your file.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

08207 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No.

08191-24

1. PLACE OF DEATH a. COUNTY <u>Anne Arundel</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Pasadena</u>		c. LENGTH OF STAY IN 1b	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Dellchaven Beach</u>		d. STREET ADDRESS <u>375 Quarry Avenue</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>CHARLES</u> Middle <u>FRANCIS</u> Last <u>MURK</u>		4. DATE OF DEATH Month <u>August</u> Day <u>26</u> Year <u>1957</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>	8. DATE OF BIRTH <u>June 8, 1915</u> <u>1929</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Truck Driver</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Consolidated Del.</u>	
11. BIRTHPLACE (State or foreign country) <u>Baltimore, Md.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Lawrence P. Murk</u>		14. MOTHER'S MAIDEN NAME <u>MELVIN</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>216-05-1164</u>	
17. INFORMANT <u>Mrs. Nellie M. Murk</u>		Address <u>3845 Quarry Ave.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c.)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Drowning</u> <u>9298</u> DUE TO Conditions, if any, which gave rise to immediate cause (b) (a), stating the underlying cause last. (c) DUE TO PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Drowned</u>			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>Drowned</u>	
20c. TIME OF INJURY Month, Day, Year <u>Aug. 26, 1957</u> Hour <u>1:17</u> p. m.	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>Water</u>	20f. (City or town) (County) (State) <u>Anne Arundel Md.</u>
21. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and find that death resulted from: Natural causes <input type="checkbox"/> , Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .			
ACTUAL SIGNATURE <u>Russell S. Fisher</u>		M.D. CHIEF MEDICAL EXAMINER <input checked="" type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) <u>Russell S. Fisher, M.D.</u>		DATE SIGNED <u>8/26/57</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>Aug 31/57</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Woodlawn</u>	22d. LOCATION (City, town, or county) (State) <u>Woodlawn Md.</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>Austin E. Norman - 3815 Potomac Ave</u>		24a. REC'D BY REGISTRAR <u>SEP 3 1957</u>	24b. REGISTRAR'S SIGNATURE <u>L. J. Asch</u>

MEDICAL CERTIFICATION

BUREAU V. S.

23 8 1967

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out, the funeral director, page 3 of this certificate should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
 TSM 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

08192

08208

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Anne Arundal MARYLAND			2. USUAL RESIDENCE (Where deceased lived. If institution—Residence before admission) a. STATE Md. b. COUNTY Balto City		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Crownsville, Md.			c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Balto City, Md.		
c. LENGTH OF STAY IN lb 5y, 4m, 11d					
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Crownsville State Hospital, Md.			d. STREET ADDRESS 118 N Mount St.		
3. NAME OF DECEASED (Type or print) First Roland Middle Harry Last Nash			4. DATE OF DEATH Month 8 Day 30 Year 1957		
5. SEX male	6. COLOR OR RACE colored	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH May 30 ?? 1898 ?		9. AGE (In years last birthday) yrs. 59
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Odd jobber		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Balto... Md.	12. CITIZEN OF WHAT COUNTRY? U.S.A.
13. FATHER'S NAME Henry Nash			14. MOTHER'S MAIDEN NAME Rosetta Hughes		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) unknown		16. SOCIAL SECURITY NO. unknown	17. INFORMANT Address Records of Crownsville State Hospital		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Congestive Heartfailure 23x DUE TO Conditions, if any, which gave rise to immediate cause (b), stating the underlying cause last. (b) Syphilitic and arteriosclerotic cardiovascular disease DUE TO (c) unknown					INTERVAL BETWEEN ONSET AND DEATH 2 days
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) none					19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour 9 p. m.	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) Balto.	(County) Md.	(State)
21. I certify that I attended the deceased from May, 20 , 1952, to August, 30 , 1957, that I last saw the deceased alive on 8/30/57 , and that death occurred at 9.25pM , from the causes and on the date stated above.					
ACTUAL SIGNATURE <i>[Signature]</i>		M.D. Crownsville State Hospital		DATE SIGNED 8/31/57	
PHYSICIAN'S NAME (Type) Ludwig Benedict, M.D.					
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF Sept. 4, 1957	22c. NAME OF CEMETERY OR CREMATORY Mt. Auburn Cem.	22d. LOCATION (City, town, or county) (State) Balto. Md.		
23. FUNERAL DIRECTOR'S SIGNATURE <i>[Signature]</i>		ADDRESS 322 E. Schaefer	24a. REC'D BY REGISTRAR SEP 4 1957	24b. REGISTRAR'S SIGNATURE <i>[Signature]</i>	

MEDICAL CERTIFICATION

2

1

BUREAU V. S.

SEP 2 1955

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

08193

08151

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Anne Arundel</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived If institution Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Anne Arundel</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Annapolis</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Shadyside</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Anne Arundel General Hospital</u>				d. STREET ADDRESS <u>Franklin & Cathedral Sts.</u>			
3. NAME OF DECEASED (Type or print) First <u>NOT NAMED</u> Middle <u></u> Last <u>Nick</u>				4. DATE OF DEATH Month <u>8</u> Day <u>1</u> Year <u>19 57</u>			
5. SEX <u>M</u>		6. COLOR OR RACE <u>Negro</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>7/31/57</u>	
9. AGE (In years last birthday) <u>14</u>		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)	
12. CITIZEN OF WHAT COUNTRY		13. FATHER'S NAME <u>???</u>		14. MOTHER'S MAIDEN NAME <u>Velma C. NICK</u>		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>	
16. SOCIAL SECURITY NO		17. INFORMANT		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Prematurity</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u></u> DUE TO (c) <u></u>		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour <u>19</u> a. m. p. m.				20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>7/31</u>	
20f. (City or town) <u>Shadyside</u>				20g. (County) <u>md</u>		20h. (State) <u>md</u>	
21. I certify that I attended the deceased from <u>8/1</u> 19 <u>57</u> , to <u>8/1</u> 19 <u>57</u> , that I last saw the deceased alive on <u>8/1</u> 19 <u>57</u> , and that death occurred at <u>12:30</u> P. M., from the causes and on the date stated above.							
ADDRESS (Street, city or town, state) <u>69 Franklin St Annapolis, Md</u>				DATE SIGNED <u>8/7/57</u>			
ACTUAL SIGNATURE <u>Robert A. Riley Jr.</u> M.D.							
PHYSICIAN'S NAME (Type) <u>ROBERT A. RILEY, Jr</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Aug 8/1957</u>		22b. DATE THEREOF		22c. NAME OF CEMETERY OR CREMATORY <u>St Matthews</u>		22d. LOCATION (City, town, or county) <u>shadyside</u>	
22e. (State) <u>md</u>		22f. (County) <u>md</u>		22g. (State) <u>md</u>		22h. (County) <u>md</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>[Signature]</u>				ADDRESS <u>Annapolis</u>		24a. REC'D BY REGISTRAR <u>Aug 9 1957</u>	
24b. REGISTRAR'S SIGNATURE <u>[Signature]</u>							

BUREAU V. S.

1957

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
08152 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

08194

Reg. Dist. No. *21*

1. PLACE OF DEATH a. COUNTY <i>A.A. Co.</i> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <i>WASH. D.C.</i> b. COUNTY			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Annapolis</i>		c. LENGTH OF STAY IN 1b		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>47X</i>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <i>ANNE ARUNDEL GENERAL</i>				d. STREET ADDRESS <i>5361-CHILLUM. #14</i>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <i>Robert</i> Middle <i>C.</i> Last <i>OBERST</i>				4. DATE OF DEATH Month <i>8</i> Day <i>17</i> Year <i>1957</i>			
5. SEX <i>M</i>	6. COLOR OR RACE <i>W</i>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>5/7/1941</i>		9. AGE (in years last birthday) <i>16</i> yrs.	IF UNDER 1 YEAR Months Days	IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Student</i>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <i>Washington, D.C.</i>		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME <i>Robert P. Oberst</i>				14. MOTHER'S MAIDEN NAME <i>Louise Price</i>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <i>no</i>		16. SOCIAL SECURITY NO. <i>no</i>		17. INFORMANT Address <i>N.E.</i> <i>Mrs. Louise Kruse - 5361 Chillum Place</i>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Fracture skull - multiple lacerations</i> DUE TO (b) <i>Free</i> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last, (c) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						INTERVAL BETWEEN ONSET AND DEATH <i>within</i>	
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.) <i>Auto accident R # 2</i>					
20c. TIME OF INJURY Month, Day, Year Hour a. m. <i>5-17 1957</i>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <i>Highway</i>		20f. (City or town) (County) (State) <i>A.A. Co MD</i>	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and find that death resulted from: Natural causes <input type="checkbox"/> , Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .							
ACTUAL SIGNATURE <i>E. Linhardt</i>				M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>			
EXAMINER'S NAME (Type) <i>E. Linhardt</i>				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
				DEPUTY MED CAL EXAMINER <input checked="" type="checkbox"/>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>		22b. DATE THEREOF <i>8/20/57</i>		22c. NAME OF CEMETERY OR CREMATORY <i>Arlington National Cem. - Arlington, Virginia</i>		22d. LOCATION (City, town, or county) (State) <i>N.E.</i>	
23. FUNERAL DIRECTOR'S SIGNATURE <i>The S.H. Hines Co. - 2901 14th St. N.W.</i>				24a. REC'D BY REGISTRAR <i>Aug 19 1957</i>		24b. REGISTRAR'S SIGNATURE <i>Wm J. Lynch</i>	

MEDICAL CERTIFICATION

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your records. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

BUREAU V. S.

AUG 19 1957

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

08195

08209

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Anne Arundel MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Anne Arundel			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Jessups				c. LENGTH OF STAY IN 1b Over 10 yrs.			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Route 175				d. STREET ADDRESS Route 175			
3. NAME OF DECEASED (Type or print) First LOUIS Middle RICHARD Last O'NEILL				4. DATE OF DEATH Month August Day 18 Year 19 57			
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 7/8/01	
9. AGE (In years last birthday) 56 yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired guard of Md. House Correction.		11. BIRTHPLACE (State or foreign country) Guilford, Md.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Michael O'Neill				14. MOTHER'S MAIDEN NAME Unknown Mary Welsh			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. 216-36-8730		17. INFORMANT Address Mrs. Margaret J. Athey (daughter)			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Fatty Liver with Ulcerative Esophagitis and Gastro-Intestinal Hemorrhage. CHOLERA Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last, (b) DUE TO (c)							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>							
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input type="checkbox"/> , and find that death resulted from: Natural cause <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .							
ACTUAL SIGNATURE <i>Paul F. Guerin</i>				M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> DEPUTY MEDICAL EXAMINER <input type="checkbox"/>			
EXAMINER'S NAME (Type) Paul F. Guerin, M.D.				DATE SIGNED 8/19/57			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 8/22/57.		22c. NAME OF CEMETERY OR CREMATORY St. Mary's Cemetery		22d. LOCATION (City, town, or county) (State) Laurel, Maryland.	
23. FUNERAL DIRECTOR'S SIGNATURE <i>Easton Bond, Catonsville, 28, Md</i>				24a. REC'D BY REGISTRAR AUG 21 1957		24b. REGISTRAR'S SIGNATURE <i>Cara Skelley</i>	

MEDICAL CERTIFICATION

TO THE DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your file. TO THE FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

BUREAU V. S.

AUG 21 1957

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

08153

CERTIFICATE OF DEATH

08196

Reg. Dist. No.

21

1. PLACE OF DEATH a. COUNTY Anne Arundel MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission) a. STATE Maryland b. COUNTY Anne Arundel			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Annapolis				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Annapolis			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION The Anne Arundel General Hospital				d. STREET ADDRESS 80 West Washington Street			
3. NAME OF DECEASED (Type or print) First Baby boy Middle Parker Last Parker				4. DATE OF DEATH Month August Day 7 Year 19 57			
5. SEX Male	6. COLOR OR RACE Negro	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH August 6, 1957	9. AGE (In years last birthday) yrs	IF UNDER 1 YEAR Months 1 Days	IF UNDER 24 HRS. Hours 1 Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME Louis Landale Smith				14. MOTHER'S MAIDEN NAME Myrtle Effie Parker			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Not no. or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	17. INFORMANT Mother Address 80 W. Washington Street				
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Atelectasis of both lungs DUE TO Cause unknown Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Cause unknown DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Post Maturity Syndrome						INTERVAL BETWEEN ONSET AND DEATH	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.	20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)			
21. I certify that I attended the deceased from August 4, 1957 to August 7, 1957 that I last saw the deceased alive on August 7, 1957 and that death occurred at 2:45 PM from the causes and on the date stated above.							
ACTUAL SIGNATURE R. L. Richardson		M.D. 110-CLAY ST ANNAPOLIS MD		DATE SIGNED 8/7/57			
PHYSICIAN'S NAME (Type) Dr. R. L. Richardson Clay St., Annapolis, Md.							
22a. BURIAL, CREMATION, REMOVAL (Specify)	22b. DATE THEREOF 8-13-57	22c. NAME OF CEMETERY OR CREMATORY Brewer Hill		22d. LOCATION (City, town, or county) (State) Annapolis, Md.			
23. FUNERAL DIRECTOR'S SIGNATURE William E. ...		ADDRESS ...		24a. REC'D BY REGISTRAR ...		24b. REGISTRAR'S SIGNATURE ...	

BUREAU V. 3

AUG 28 1977

RECEIVED

CERTIFICATE OF DEATH

Reg. Dist. No.

08210

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <u>A. A. Co.</u>		MARYLAND		STATE <u>Md.</u>		COUNTY <u>A A Co</u>	
CITY (If outside corporate limits, write RURAL and give nearest town)		LENGTH OF STAY (In this place)		CITY (If outside corporate limits, write RURAL and give nearest town)		OR TOWN	
TOWN <u>Deale</u>		<u>4 days</u>		TOWN <u>Deale, Md.</u>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS				STREET ADDRESS (If rural give location)			
3. NAME OF DECEASED (Type or Print)				4. DATE OF DEATH			
(First) <u>Bernard</u> (Middle) <u>Lucius</u> (Last) <u>Phipps</u>				(Month) <u>Aug</u> (Day) <u>26</u> (Year) <u>19 57</u>			
5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE last birthday	IF UNDER 1 YEAR		IF UNDER 24 HRS.
<u>Male</u>	<u>White</u>	<u>MARRIED</u>	<u>Nov. 8, 1890</u>	<u>66</u> yrs.	Months	Days	Hours Min
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?	
<u>WATERMAN</u>		<u>Seafood</u>		<u>Churchton Md.</u>		<u>U.S.A.</u>	
13. FATHER'S NAME				14. MOTHER'S MAIDEN NAME			
<u>James Phipps</u>				<u>SARAH Christine Atwell</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.)				16. SOCIAL SECURITY NO		17. INFORMANT & ADDRESS	
<u>No</u> (If Yes, give war or dates of service)				<u>2:2-36-8893</u>		<u>LENA Phipps Deale, Md</u>	
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH						18. MEDICAL CERTIFICATION	
442X IMMEDIATE CAUSE (A)						INTERVAL BETWEEN ONSET AND DEATH	
<u>Complete Heart Block</u>						<u>4 days</u>	
ANTECEDENT CAUSE(S) DUE TO							
<u>Arteriosclerotic C.V.R. Disease</u>						<u>10 yrs</u>	
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (C)							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION				19b. MAJOR FINDINGS OF OPERATION			
21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town)		(County) (State)	
21d. TIME OF INJURY (Month) (Day) (Year) (Hour)		21e. INJURY OCCURRED While at work Not while at work		21f. HOW DID INJURY OCCUR?			
		M. <input type="checkbox"/> <input type="checkbox"/>					
22. I hereby certify that I attended the deceased from <u>June 19 54</u> to <u>26 Aug 57</u> , that I last saw the deceased alive on <u>25 Aug 57</u> , and that death occurred at <u>3:20 P.M.</u> from the causes and on the date stated above.							
SIGNATURE <u>[Signature]</u>				DATE SIGNED <u>30 Aug 57</u>			
ADDRESS (Street, city, town, state)							
23. BURIAL, CREMATION, REMOVAL (SPECIFY)		DATE THEREOF		NAME OF CEMETERY OR CREMATORY		LOCATION (City, town, or county) (State)	
<u>BURIAL</u>		<u>Aug 29 1957</u>		<u>St. James Cem</u>		<u>Tracy's Landing, Md</u>	
24. REGD. BY REGISTRAR		REGISTRAR'S SIGNATURE		25. FUNERAL DIRECTOR'S SIGNATURE		ADDRESS	
<u>[Signature]</u>		<u>[Signature]</u>		<u>Bernard Hurdant, Lakeside, Md</u>			
DATE <u>9/6/57</u>							

INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. The body copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS AISC 1-55 10M

BUREAU V. S.

1917

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3, should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

08211

CERTIFICATE OF DEATH

08198

Reg. Dist. No. 27

1. PLACE OF DEATH a. COUNTY <u>Anne Arundel</u> <u>MARYLAND</u>				2. USUAL RESIDENCE (Where deceased lived. If institution Residence before admission) a. STATE <u>New Mexico</u> b. COUNTY <u>Bernalillo</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Fort George G. Meade</u>				c. LENGTH OF STAY IN 1b <u>25 hrs 3 min</u>			
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Albuquerque</u>				d. STREET ADDRESS <u>824 Adams Street, N.E.</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>U. S. Army Hospital</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <u>DAVID</u> Middle <u>LAWRENCE</u> Last <u>PIRKLE</u>				4. DATE OF DEATH Month <u>AUGUST</u> Day <u>22</u> Year <u>1957</u>			
5. SEX <u>Male</u>		6. COLOR OR RACE <u>Cau</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>21/August/57</u>	
9. AGE (In years last birthday) yrs.		IF UNDER 1 YEAR Months <u>25</u> Days <u>3</u>		IF UNDER 24 HRS Hours <u>25</u> Min. <u>3</u>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>None</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>None</u>		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>	
12. CITIZEN OF WHAT COUNTRY? <u>USA</u>							
13. FATHER'S NAME <u>Lowell Zinn Pirkle</u>				14. MOTHER'S MAIDEN NAME <u>Deborah Lou Kitch</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>No</u>				16. SOCIAL SECURITY NO <u>None</u>		17. INFORMANT <u>Father, 609 Fairlawn Avenue, Apt 5, Laurel, Maryland</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Neoplasm in retroperitoneal space</u> DUE TO <u>Incomplete expansion of both lungs</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>158x</u> (c) <u>158x</u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>158x</u>							
INTERVAL BETWEEN ONSET AND DEATH							
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)				20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)			
20c. TIME OF INJURY Month, Day, Year Hour a. p. m. <u>19</u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town)				20g. (County)		20h. (State)	
21. I certify that I attended the deceased from <u>0300 21 Aug 1957</u> to <u>22 Aug 1957</u> , that I last saw the deceased alive on <u>22 Aug 1957</u> , and that death occurred at <u>0403 AM</u> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) <u>0403 AM</u> DATE SIGNED <u>22 Aug 57</u>							
ACTUAL SIGNATURE <u>John P. Bergstrom</u> M.D. <u>USAH, Fort G. G. Meade, Md.</u>				22. NAME OF CEMETERY OR CREMATORY <u>Parkview Cemetery</u>			
PHYSICIAN'S NAME (Type) <u>BERGSTROM JOHN P. CAPT. M.C.</u>				22d. LOCATION (City, town, or county) (State) <u>Albuquerque, New Mexico</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Removal</u>				22b. DATE THEREOF <u>Aug. 23, 1957</u>			
23. FUNERAL DIRECTOR'S SIGNATURE <u>William Cook, Inc.</u>				ADDRESS <u>1217 St. Paul Street</u>			
24a. REC'D BY REGISTRAR <u>22 Aug 57</u>				24b. REGISTRAR'S SIGNATURE <u>Wilbur H. Downs, Jr. Capt. MSC</u>			

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U. S. A.

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RECEIVED

CERTIFICATE OF DEATH

Reg. Dist. No.

08212

1. PLACE OF DEATH a. COUNTY Anne Arundel MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution Residence before admission) a. STATE Maryland b. COUNTY Prince Georges			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Crownsville				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Annapolis			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Crownsville State				d. STREET ADDRESS RFD #2, Box 592			
3. NAME OF DECEASED (Type or print) First Middle Last Vesta Porter				4. DATE OF DEATH Month Day Year 8 23 19 57			
5. SEX Female	6. COLOR OR RACE Negro	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH unknown		9. AGE (In years last birthday) 24 yrs	10. IF UNDER 1 YEAR Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) unknown		10b. KIND OF BUSINESS OR INDUSTRY -----		11. BIRTHPLACE (State or foreign country) Annapolis, Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Herbert Porter				14. MOTHER'S MAIDEN NAME Frances Porter			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) -----		16. SOCIAL SECURITY NO. -----		17. INFORMANT Address Hospital Records Crownsville, Md.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Malnutrition and Dehydration 355 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under-lying cause lost. (b) Old Post Traumatic Cerebral Atrophy DUE TO (c) ----- PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 1) Microcephaly 2) Anemia 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. s. p. m. 19		20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 8-20- 19 57 to 8-23- 19 57 , that I last saw the deceased alive on 8-23 19 57 and that death occurred at 9:30 a.m. from the causes and on the date stated above. ADDRESS (Street, city or town, state) Crownsville, Maryland DATE SIGNED 8-23-57							
ACTUAL SIGNATURE Lionel McHenry Mapp		M.D. Crownsville, Maryland 8-23-57					
NAME (Type) Lionel McHenry Mapp, M.D.							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 8-25-57		22c. NAME OF CEMETERY OR CREMATORY Calvary Cem.		22d. LOCATION (City, town, or county) (State) Arnold, Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE William Reese, Jr. Anna, Md.				24a. REC'D BY REGISTRAR DATE 8/27/57		24b. REGISTRAR'S SIGNATURE S. M. Jones	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4

may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 of this certificate should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

BUREAU V. S.

106 7 1957

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

08154

CERTIFICATE OF DEATH

08200 21
Reg. Dist. No.

1. PLACE OF BIRTH a. COUNTY <u>Anne Arundel</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>C.C.</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Annapolis</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Annapolis</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) <u>1029 Smithville St.</u>		d. STREET ADDRESS <u>1029 Smithville St.</u>	
3. NAME OF DECEASED (Type or print) <u>Gladys</u> First <u>M</u> Middle <u>Powell</u> Last		4. DATE OF DEATH Month <u>8</u> Day <u>25</u> Year <u>1957</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>Col.</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>7-17-1919</u>
9. AGE (In years last birthday) <u>38</u> yrs.		IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Fredrick Makell</u>		14. MOTHER'S MAIDEN NAME <u>Agnes Biss</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>—</u>	
17. INFORMANT <u>Agnes Makell - Annapolis, Md.</u>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Carcinoma of the Rectum</u> <u>154X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) DUE TO		INTERVAL BETWEEN ONSET AND DEATH <u>2 years</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <u>August 1955</u> to <u>8/25/57</u> , that I last saw the deceased alive on <u>8/25/57</u> , and that death occurred at <u>6:15 P.M.</u> from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>R. F. Richardson</u>		ADDRESS (Street, city or town, state) <u>110-CLAY ST ANNAPOLIS, MD.</u>	
PHYSICIAN'S NAME (Type) <u>William Reese, Jr. - Anna, Md.</u>		DATE SIGNED <u>8/28/57</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify)	22b. DATE THEREOF <u>8-29-57</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Brewer Hill</u>	22d. LOCATION (City, town, or county) (State) <u>Annapolis, Md.</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>William Reese, Jr. - Anna, Md.</u>		24a. REC'D BY REGISTRAR <u>Wm. J. French</u>	
24b. REGISTRAR'S SIGNATURE		DATE <u>Aug 28 1957</u>	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death: Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

BUREAU V. S.

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RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

08213

CERTIFICATE OF DEATH

08201

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY AA. MARYLAND		2. USUAL RESIDENCE (Where deceased lived If institution Residence before admission) o. STATE Md. b. COUNTY A. A.	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Ferndale		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) XO Ferndale	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 103 - 1st Ave. South		d. STREET ADDRESS 103 - 1st Ave. South e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) Effie Elizabeth Pumphrey		4. DATE OF DEATH Jan 23 Day Year 1957	
5. SEX F	6. COLOR OR RACE W	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH July 3 4 77 9. AGE (In years last birthday) 80 yrs
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) Ferndale Md.		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME Wm H. Downs		14. MOTHER'S MAIDEN NAME Elizabeth Wellman	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. NONE 17. INFORMANT Luther Pumphrey Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cardio Vascular Disease 22.1 DUE TO Arteriosclerosis Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c)			INTERVAL BETWEEN ONSET AND DEATH 6 am - 10 pm
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19	20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input checked="" type="checkbox"/> of work <input type="checkbox"/> or work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from Feb 1945 to Aug 23 1957 that I last saw the deceased alive on Aug 5 1957 , and that death occurred at 10 AM , from the causes and on the date stated above.			
ACTUAL SIGNATURE Chas L. Ball Jr. M.D.		ADDRESS (Street, city or town, state) Linthicum, Md. DATE SIGNED 8/23/57	
NAME (Type)			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF 8/26/57	22c. NAME OF CEMETERY OR CREMATORY Cedar Hill Cem.	22d. LOCATION (City, town, or county) (State) Baltimore, Md.
23. FUNERAL DIRECTOR'S SIGNATURE Wm J. Vickers ADDRESS 4401 S. Bay		24. REG'D BY REGISTRAR 17 AUG 27 1957 25. REGISTRAR'S SIGNATURE L. G. Seabury	

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BUREAU V. S.

08155 CERTIFICATE OF DEATH

08202
Reg. Dist. No. 21

1 PLACE OF DEATH a COUNTY Anne Arundel MARYLAND		2 USUAL RESIDENCE (Where deceased lived. If institution Residence before admission) a. STATE Maryland b. COUNTY Anne Arundel	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Annapolis		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) (Bay Ridge) Annapolis X	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Anne Arundel General Hospital		d. STREET ADDRESS 34 River Rd.	
3. NAME OF DECEASED (Type or print) ALBERT A RILEY		4. DATE OF DEATH August 20 19 57	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH August 5, 1900
9. AGE (In years last birthday) 57 yrs		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Equipment Specialist	
11. BIRTHPLACE (State or foreign country) Virginia		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Frank Riley		14. MOTHER'S MAIDEN NAME May Cash	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO. none	
17. INFORMANT Mrs Kathleen V. Riley- Wife- Same as # 2		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) myocardial infarction 410X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Rheumatic Heart Disease DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) old multiple kidney infarction		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from Feb 20, 1957 to 8-20-57 , that I last saw the deceased alive on 8-20-57 , and that death occurred at 6:20 M., from the causes and on the date stated above.			
ACTUAL SIGNATURE Frank M Shipley M.D.		ADDRESS (Street, city or town, state) 63 College Ave. Annapolis, Maryland	
DATE SIGNED 8.22.57			
PHYSICIAN'S NAME (Type) Frank Shipley			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF Aug. 24, 57	22c. NAME OF CEMETERY OR CREMATORY Cedar Hill Cemetery	22d. LOCATION (City, town, or county) (State) Prince George County, Maryland
23. FUNERAL DIRECTOR'S SIGNATURE HOPPING FUNERAL HOME		ADDRESS Annapolis, Maryland	
24a. REC'D BY REGISTRAR 8/27/57		24b. REGISTRAR'S SIGNATURE My J. French	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 1 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

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1957

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

08214

CERTIFICATE OF DEATH

08203

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Anne Arundel MARYLAND		2. USUAL RESIDENCE (Where deceased lived If institution Residence before admission) a. STATE Maryland b. COUNTY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Crownsville		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Crownsville State		d. STREET ADDRESS 1108 Greenmont Avenue	
3. NAME OF DECEASED (Type or print) First Doretta Middle Ross Last Ross		4. DATE OF DEATH Month 8 Day 25 Year 1957	
5. SEX Female	6. COLOR OR RACE Negro	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>	8. DATE OF BIRTH January 28, 1920
9. AGE (In years last birthday) yrs. 37		IF UNDER 1 YEAR Months Days Hours Min. IF UNDER 24 HRS.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Laundry Worker		10b. KIND OF BUSINESS OR INDUSTRY ---	
11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Calvin Ross		14. MOTHER'S MAIDEN NAME Mary Ross	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) [If yes, give war or dates of service] ---		16. SOCIAL SECURITY NO. ---	
17. INFORMANT Hospital Records		Address Crownsville, Maryland	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral Thrombosis DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Arteriosclerosis DUE TO (c) Dehydration and Hyperglycemia PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Dehydration and Hyperglycemia			
INTERVAL BETWEEN ONSET AND DEATH			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from July 7, 1957 , to August 25, 1957 , that I last saw the deceased alive on 8-25-57 , and that death occurred at 5:10 a.m. , from the causes and on the date stated above			
ACTUAL SIGNATURE Lionel McHenry Mapp		ADDRESS (Street, city or town, state) Crownsville, Maryland DATE SIGNED 8-26-57	
PHYSICIAN'S NAME (Type) Lionel McHenry Mapp, M.D.			
22a. BURIAL, CREMATION, REMOVAL (Specify) burial		22b. DATE THEREOF 8-30-57	
22c. NAME OF CEMETERY OR CREMATORY Greenwood		22d. LOCATION (City, town, or county) (State) Baltimore	
23. FUNERAL DIRECTOR'S SIGNATURE L. M. Jones		ADDRESS 1108 Greenmont Avenue	
24a. REC'D BY REGISTRAR R. M. Jones		DATE 9/3/57	

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BUREAU V. S.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

08215

CERTIFICATE OF DEATH

08204

Reg. Dist. No.

24

1. PLACE OF DEATH a. COUNTY <u>Anne Arundel</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Anne Arundel</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Pasadena RFD</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Pasadena RFD</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Box 412 - Lake Shore</u>				d. STREET ADDRESS <u>Box 412 - Lake Shore</u>			
3. NAME OF DECEASED (Type or print) First <u>William</u> Middle <u>Henry</u> Last <u>Rothamel</u>				4. DATE OF DEATH Month <u>August</u> Day <u>6</u> Year <u>1957</u>			
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Feb-21, 1864</u>		9. AGE (If years last birthday) <u>93</u> yrs.	10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Farmer (ret.)</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>Self Emp.</u>		11. BIRTHPLACE (State or foreign country) <u>Ba Har Md.</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>							
13. FATHER'S NAME <u>George Rothamel</u>				14. MOTHER'S MAIDEN NAME <u>Anna Zimmerman</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes, give war or dates of service) <u>--</u>				16. SOCIAL SECURITY NO. <u>None</u>		17. INFORMANT Address <u>Mrs. Mary Rothamel Same As #2</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>4221 Acute cardiac decompensation</u> DUE TO <u>Arteriosclerotic Cardiovascular disease</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>several months</u> DUE TO (c)						INTERVAL BETWEEN ONSET AND DEATH <u>2 weeks</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>none</u>							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from <u>July 20</u> , 19 <u>55</u> , to <u>Aug 6</u> , 19 <u>57</u> , that I last saw the deceased alive on <u>August 5</u> , 19 <u>57</u> , and that death occurred at <u>2:07 PM</u> , from the causes and on the date stated above.							
ADDRESS (Street, city or town, state) <u>Pasadena, Md.</u>				DATE SIGNED <u>August 6, 1957</u>			
ACTUAL SIGNATURE <u>R. M. McLaughlin</u> M.D.							
PHYSICIAN'S NAME (Type) <u>R. M. McLaughlin, M.D.</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>Aug. 9, 1957</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Glen Haven</u>		22d. LOCATION (City, town, or county) (State) <u>Glen Burnie Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>R. L. Smith</u> ADDRESS <u>Glen Burnie, Md.</u>				24a. REC'D BY REGISTRAR (Type) REGISTRAR'S SIGNATURE <u>L. J. Adkins</u> DATE <u>AUG 12 1957</u>			

BUREAU V. S.

AUG 12 1957

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

08216

CERTIFICATE OF DEATH

08205

Reg. Dist. No.

28

1. PLACE OF DEATH a. COUNTY Anne Arundel MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution Residence before admission) a. STATE Maryland b. COUNTY Baltimore City	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Crownsville, Md.		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore City	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Crownsville State Hospital		d. STREET ADDRESS 1127 Pennsylvania Avenue	
3. NAME OF DECEASED (Type or print) First Lester Middle Saunders Last Saunders		4. DATE OF DEATH Month 8 Day 17 Year 19 57	
5. SEX Male	6. COLOR OR RACE Negro	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Unknown
9. AGE (In years last birthday) 56? yrs.		IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Unknown		10b. KIND OF BUSINESS OR INDUSTRY Unknown	
11. BIRTHPLACE (State or foreign country) Unknown		12. CITIZEN OF WHAT COUNTRY? U. S.	
13. FATHER'S NAME Unknown		14. MOTHER'S MAIDEN NAME Unknown	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) Unknown		16. SOCIAL SECURITY NO. Unknown	
17. INFORMANT Hospital records		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebro-Vascular Accident (cerebral hemorrhage) 060X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) CNS Lues DUE TO (c) 10 days 2 years			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. 9 p. m. 9		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from January 17, 19 57 , to August 17, 19 57 , that I last saw the deceased alive on August 17, 19 57 , and that death occurred at 12:08 a.m. , from the causes and on the date stated above.			
ACTUAL SIGNATURE Conwell Newton, M.D.		ADDRESS (Street, city or town, state) Crownsville State Hospital, Md. DATE SIGNED 8/20/57	
PHYSICIAN'S NAME (Type) Conwell Newton, M. D.		Crownsville, Md.	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF Aug 21	
22c. NAME OF CEMETERY OR CREMATORY Mt Carmel		22d. LOCATION (City, town, or county) (State) Baltimore Md	
23. FUNERAL DIRECTOR'S SIGNATURE G. H. Adams		24a. REC'D BY REGISTRAR 8/23/57	
ADDRESS P. O. Box 11111		24b. REGISTRAR'S SIGNATURE H. M. Joyce	

BUREAU V. S.

UG 2 1957

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

08156 CERTIFICATE OF DEATH

0820621

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Anne Arundel MARYLAND				2. USUAL RESIDENCE (Where deceased lived If institution: Residence before admission) a. STATE Maryland b. COUNTY Anne Arundel			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Annapolis				c. LENGTH OF STAY IN 1b Millersville Rural			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Anne Arundel General Hospital				d. STREET ADDRESS Crownsville Post Office			
3. NAME OF DECEASED (Type or print) First Charles Middle B Last Smith				4. DATE OF DEATH Month August Day 14 Year 19 57			
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH November 6, 1957	9. AGE (In years last birthday) 73 yrs	IF UNDER 1 YEAR Months	IF UNDER 24 HRS. Days	Hours
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Storkeeper		10b. KIND OF BUSINESS OR INDUSTRY State Hospital		11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Charles B. Smith				14. MOTHER'S MAIDEN NAME Annie Insley			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO. (If yes, give year or dates of service) none		17. INFORMANT Charles O. Smith; Son; Gambrills, Maryland			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary Thrombosis DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Coronary Artery Disease DUE TO (c)							INTERVAL BETWEEN ONSET AND DEATH 1 Hour 5 Years
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from Oct 1956 to Aug 14 1957 , that I last saw the deceased alive on Aug 10 1957 , and that death occurred at 8:25AM , from the causes and on the date stated above. ADDRESS (Street, city or town, state) Gambrills DATE SIGNED 8-14-57 SIGNATURE Edward G. Skeritt M.D. Gambrills PHYSICIAN'S NAME (Type) Edward Skeritt							
22a. BURIAL, CREMATION, REMOVAL (Specify)		22b. DATE THEREOF		22c. NAME OF CEMETERY OR CREMATORY		22d. LOCATION (City, town, or county) (State)	
Baldwin Memorial Cemet.		8-17-57		Millersville, Md.			
23. FUNERAL DIRECTOR'S SIGNATURE HOPPING FUNERAL HOME				24a. REC'D BY REGISTRAR AUG 19 1957		24b. REGISTRAR'S SIGNATURE Mr. J. Thunberg	

RECEIVED
JUL 19 1957
U. S. A.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your file.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

VS. A15ME(5)
SM 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

08157 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

08207 21
Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <i>A.A.CO</i> MARYLAND			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <i>MD</i> b. COUNTY <i>Prince George's</i>		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Annapolis Md</i>			c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>W. Hyattsville</i>		
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <i>Emergency Hospital</i>			d. STREET ADDRESS <i>3200 Kimberley Rd</i>		
3. NAME OF DECEASED (Type or print) <i>CHARLOTTE ANN Smith</i> Middle Last			4. DATE OF DEATH Month <i>8</i> Day <i>17</i> Year <i>1957</i>		
5 SEX <i>F</i>	6. COLOR OR RACE <i>W</i>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>August 15, 1943</i>		9. AGE (In years last birthday) <i>14</i> yrs.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Student</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>School</i>		11. BIRTHPLACE (State or foreign country) <i>Washington D. C.</i>	12. CITIZEN OF WHAT COUNTRY? <i>U.S.A</i>
13. FATHER'S NAME <i>Melvin E. Smith</i>			14. MOTHER'S MAIDEN NAME <i>Cleo G. Fisher</i>		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <i>no</i>		16. SOCIAL SECURITY NO. <i>none</i>		17. INFORMANT <i>Melvin E. Smith W Hyattsville, Md.</i>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Fracture - Skull - Multiple contusions</i> DUE TO (b) <i>Lips, face, upper extremities</i> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c) <i>sudden</i>					
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <i>Auto accident R#2</i>			
20c. TIME OF INJURY Month, Day, Year Hour <i>5-17</i> 1957	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <i>Highway</i>		20f. (City or town) (County) (State) <i>A.A.CO.</i>
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and find that death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/> .					
ACTUAL SIGNATURE <i>E. Linhardt</i>		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>		DATE SIGNED <i>5-17-57</i>	
EXAMINER'S NAME (Type) <i>E. Linhardt</i>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>	22b. DATE THEREOF <i>8/20/57</i>	22c. NAME OF CEMETERY OR CREMATOR <i>Arlington National</i>		22d. LOCATION (City, town, or county) (State) <i>Arlington Virginia</i>	
23. FUNERAL DIRECTOR'S SIGNATURE <i>F. Gasch's Sons</i>			ADDRESS <i>Hyattsville, Md.</i>		
24a. REC'D BY REGISTRAR			24b. REGISTRAR'S SIGNATURE <i>M. Kennedy</i>		

AUG 22 1957

RECEIVED

AUG 28 1977

BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

08158

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No.

08208

1. PLACE OF DEATH a. COUNTY <i>A.A.CO.</i> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission) a. STATE <i>MD</i> b. COUNTY <i>Pro Benger</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Armagosa Ind</i>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>W. Hyattsville - 1015</i>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <i>ANNE ARUNDEL GENERAL</i>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <i>CLEO G. Smith</i>		4. DATE OF DEATH Month <i>8</i> Day <i>17</i> Year <i>1957</i>	
5. SEX <i>F</i>	6. COLOR OR RACE <i>W</i>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>Jan 23, 1922</i>
9. AGE (In years last birthday) <i>36</i> yrs.		10. IF UNDER 1 YEAR Months <i></i> Days <i></i>	11. IF UNDER 24 HRS. Hours <i></i> Min. <i></i>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Housewife</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>own home</i>	
11. BIRTHPLACE (State or foreign country) <i>Texas</i>		12. CITIZEN OF WHAT COUNTRY? <i>USA</i>	
13. FATHER'S NAME <i>John Fisher</i>		14. MOTHER'S MAIDEN NAME	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <i>no</i>		16. SOCIAL SECURITY NO.	
17. INFORMANT <i>Melvin E. Smith</i>		Address <i>W Hyattsville, Md.</i>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Fracture-Skull - Saw - Compd. Fracture</i> 816X DUE TO (b) <i>Lower-Extremities - Multiple - contusions</i> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c) <i>AND Lacerations.</i> INTERVAL BETWEEN ONSET AND DEATH <i>Sudden.</i>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18) <i>Auto. accident - Rt 2</i>	
20c. TIME OF INJURY Month, Day, Year <i>5-17 1957</i>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <i>Highway</i>		20f. (City or town) <i>A.A.CO.</i> (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and find that death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/> .			
ACTUAL SIGNATURE <i>E. Linhardt</i>		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) <i>E. Linhardt</i>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>		22b. DATE THEREOF <i>Aug 20, 1957</i>	
22c. NAME OF CEMETERY OR REMOVAL <i>Arlington National</i>		22d. LOCATION (City, town, or county) <i>Arlington</i> (State) <i>Virginia</i>	
23. FUNERAL DIRECTOR'S SIGNATURE <i>L. Gasch's Sons</i>		ADDRESS <i>Hyattsville Md.</i>	
24a. REC'D BY REGISTRAR <i>Aug 22 1957</i>		24b. REGISTRAR'S SIGNATURE <i>Th. J. Hendry</i>	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your file.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

RECEIVED

AUG 22 1977

BUREAU V. 3

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please enclose the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File page 1 and 2 with the registrar prior to burial, cremation, or reinterment.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

08209

08159 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist No.

1. PLACE OF DEATH a. COUNTY <u>aa</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If Institution: Residence before admission) a. STATE <u>md.</u> b. COUNTY <u>aa</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Annapolis</u>				c. LENGTH OF STAY IN 1b			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>C. G. General</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <u>WILLIAM H. M.</u> Middle <u>SMITH</u> Last <u>JR</u>				4. DATE OF DEATH Month <u>8</u> - Day <u>19</u> Year <u>1957</u>			
5. SEX <u>Male</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>12-8-1936</u>	
9. AGE (In years last birthday) <u>20</u> yrs.		IF UNDER 1 YEAR Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u>		IF UNDER 24 HRS. Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Engineer</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>Engineer (consulting)</u>			
11. BIRTHPLACE (State or foreign country) <u>Annapolis Md.</u>				12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>			
13. FATHER'S NAME <u>William H. M. Smith</u>				14. MOTHER'S MAIDEN NAME <u>Martha Miller</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u> </u>				16. SOCIAL SECURITY NO. <u> </u>			
17. INFORMANT <u>W. H. M. Smith</u>				Address <u>(2)</u>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)							
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Crushing injury to Pelvis</u> DUE TO <u>Comp. fracture femur left</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) <u> </u>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u> </u>							
INTERVAL BETWEEN ONSET AND DEATH <u> </u>							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.				20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.) <u>Auto accident</u>			
20c. TIME OF INJURY Month, Day, Year <u>8/19/57</u> Hour <u>12:05</u> a.m. <u> </u> p.m. <u> </u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>			
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>Highway</u>				20f. (City or town) (County) (State) <u>Annapolis Md.</u>			
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and find that death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/>							
ACTUAL SIGNATURE <u>F. Linhardt</u>				M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>			
EXAMINER'S NAME (Type) <u>F. Linhardt</u>				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			
22a. BURIAL, CREMATION, or MOVAL (Specify) <u>Burial</u>				22b. DATE THEREOF <u>8-22-57</u>			
22c. NAME OF CEMETERY OR CREMATORY <u>St. Annes</u>				22d. LOCATION (City, town, or county) (State) <u>Annapolis Md.</u>			
23. FUNERAL DIRECTOR'S SIGNATURE <u>John W. Taylor Sons</u>				24a. REC'D BY REGISTRAR <u> </u>			
ADDRESS <u>Annapolis Md.</u>				24b. REGISTRAR'S SIGNATURE <u> </u>			
				DATE <u>8/21/57</u>			

BUREAU V. S.

AUG

RECEIVED

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute this certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME
5M 2 57

FOR STATE
HEALTH DEPT.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

08210

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY A. A. 30		b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Glen Burnie		c. LENGTH OF STAY IN 1b 2 years		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Same b. COUNTY Same c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Same		d. STREET ADDRESS Same		e. IS DECEASED ON A FERRY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>													
3. NAME OF DECEASED (Type or print) Marjorie A. Staubitz		First Middle Last		4. DATE OF DEATH August 23rd, 1957 19		Month Day Year		5. SEX F		6. COLOR OR RACE W		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 5/18/03		9. AGE (In years last birthday) 54 yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.		11. IF UNDER 24 HRS.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Florence, Howard Co. Md.		12. CITIZEN OF WHAT COUNTRY? U.S.A.		13. FATHER'S NAME Louis Ridder		14. MOTHER'S MAIDEN NAME Ella Pickett		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. None		17. INFORMANT Georges Staubitz (Husband) Same as # 2		Address		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Coronary Occlusion 4:00.1 DUE TO Conditions, if any, which gave rise to immediate cause (b) DUE TO (a), stating the underlying cause lost. (c)		INTERVAL BETWEEN ONSET AND DEATH Sudden	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)		21. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>		22. ACTUAL SIGNATURE Gustave H. Faubert, M.D.		23. CHIEF MEDICAL EXAMINER Gustave H. Faubert, M.D.		24. ASSISTANT MEDICAL EXAMINER		25. DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		DATE SIGNED 8/24/57					
26a. BURIAL, CREMATION, REMOVAL (See 18)		26b. DATE THEREOF 27 Aug. 57		26c. NAME OF CEMETERY OR CREMATORY Glen Haven Cemetery		26d. LOCATION (City, town, or county) Glen Burnie, Maryland		26e. (State) Maryland		26f. REC'D BY REGISTRAR AUG 27 1957		26g. REGISTRAR'S SIGNATURE J. J. Adley		26h. DATE AUG 27 1957		26i. (State) Maryland							

RECEIVED
AUG 7 1957
BUREAU V. S.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please enclose the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar for burial, cremation, or removal of remains.

VS. A15ME(5)
SM 9/55

08160

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

08211

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <i>A A</i> MARYLAND				2. USUAL RESIDENCE (Where deceased lived If institution: Residence before admission) a. STATE <i>Md</i> b. COUNTY <i>AA</i>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Annapolis</i>				c. LENGTH OF STAY IN 1b			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <i>A.A. General</i>				e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Annapolis</i>			
f. STREET ADDRESS <i>105 Monticello Ave</i>				g. IS RESIDENCE ON A FARM YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <i>SAMUEL S STOKES</i>				4. DATE OF DEATH Month <i>8-</i> Day <i>9-</i> Year <i>1957</i>			
5. SEX <i>Male</i>		6. COLOR OR RACE <i>White</i>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <i>8-8-1885</i>	
9. AGE (In years last birthday) <i>72</i> yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Cover of Grocery Store (Grocery)</i>		11. BIRTHPLACE (State or foreign country) <i>Baltimore Md.</i>		12. CITIZEN OF WHAT COUNTRY? <i>U.S.A</i>	
13. FATHER'S NAME <i>John A. Stokes</i>				14. MOTHER'S MAIDEN NAME <i>Elizabeth Zeigler</i>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <i>(If yes, give war or dates of service)</i>				16. SOCIAL SECURITY NO. <i>—</i>			
17. INFORMANT <i>Samuel S. Stokes Jr.</i>				Address <i>(2)</i>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>POIX</i> DUE TO <i>Cerebral Accident.</i> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) <i>Stroke</i> DUE TO <i>Stroke</i>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTR BUT NG TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <i>INTERVAL BETWEEN ONSET AND DEATH</i>							
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Hour <i>—</i> a. m. <i>—</i> p. m. <i>19</i>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and find that death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/> .							
ACTUAL SIGNATURE <i>E. L. L. L. L.</i>				M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>			
EXAMINER'S NAME (Type) <i>E. L. L. L. L.</i>				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			
22a. BURIAL, CREMATION, REMOVAL (Specify)		22b. DATE THEREOF		22c. NAME OF CEMETERY OR CREMATORY		22d. LOCATION (City, town, or county) (State)	
<i>Burial</i>		<i>8-12-57</i>		<i>Cedar Bluff</i>		<i>Annapolis Md</i>	
23. FUNERAL DIRECTOR'S SIGNATURE <i>John M. Rayle Sr.</i>				24a. REC'D BY REGISTRAR <i>9/10/57</i>			
ADDRESS <i>Annapolis</i>				REGISTRAR'S SIGNATURE <i>E. L. L. L. L.</i>			

MEDICAL CERTIFICATION

DATE SIGNED

8-9-57

BUREAU V. S.

AUG 14 1907

RECEIVED
AUG 14 1907

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrant prior to burial, cremation, or removal, and in any event within 72 hours after death.

Item 8 1-1-1 1-9-5-1 et 08161 MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18 CERTIFICATE OF DEATH

08212

Reg. Dist. No. 21

1. PLACE OF DEATH a. COUNTY Anne Arundel				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Anne Arundel			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Annapolis				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) X 2 Annapolis			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Anne Arundel General Hospital				e. STREET ADDRESS Ferry Farms			
3. NAME OF DECEASED (Type or print) AGNES MOORE STROMEYER				4. DATE OF DEATH Month Aug Day 3 Year 1957			
5. SEX F	6. COLOR OR RACE W	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 1890 Nov. 11, 1890	9. AGE (In years last birthday) 66 yrs.	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) House wife		10b. KIND OF BUSINESS OR INDUSTRY own home		11. BIRTHPLACE (State or foreign country) Annapolis, Md.		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME David Moore				14. MOTHER'S MAIDEN NAME Minnie Grollman			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) ---		16. SOCIAL SECURITY NO. ---		17. INFORMANT William F. Stromeier- Husband - same as # 2			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 420.1 Coronary occlusion DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) --- DUE TO (c) ---						INTERVAL BETWEEN ONSET AND DEATH 1 hour	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE GIVEN IN PART I (a) Jaamec's Condition, Hypertensive and Arteriosclerotic CV Pnea							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) 581.1		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) ---		20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m. ---		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) ---		20f. (City or town) ---		(County) ---		(State) ---	
21. I certify that I attended the deceased from July 25, 1957 to Aug 3, 1957 , that I last saw the deceased alive on Aug 3, 1957 , and that death occurred at 1 20 PM from the causes and on the date stated above ADDRESS (Street, city or town, state) --- DATE SIGNED August 5, 1957							
ACTUAL SIGNATURE Richard H. Peeler M.D.				DATE SIGNED August 5, 1957			
PHYSICIAN'S NAME (Type) Richard Peeler				Annapolis, Maryland			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF Aug. 6, 57		22c. NAME OF CEMETERY OR CREMATORY St. Anne's Cemetery		22d. LOCATION (City, town, or county) (State) Annapolis Md.	
23. FUNERAL DIRECTOR'S SIGNATURE Hopping Eugene J. Home				24a. REC'D BY REGISTRAR Aug 7 1957		24b. REGISTRAR'S SIGNATURE Jim French	

BUREAU V. S.

AUG 7 1904

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

08218

08218

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Anne Arundel</u> <u>MARYLAND</u>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Crownsville</u>				c. LENGTH OF STAY IN 1b <u>20yrs. 4mo. 18da.</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Crownsville State</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <u>Benjamin</u> Middle Last <u>Thomas</u>				4. DATE OF DEATH Month <u>8</u> Day <u>20</u> Year <u>19 57</u>			
5. SEX <u>Male</u>		6. COLOR OR RACE <u>Negro</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>1898?</u>	
9. AGE (In years last birthday) <u>59?</u> yrs		IF UNDER 1 YEAR Months Days Hours Min		IF UNDER 24 HRS.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Laborer</u>				10b. KIND OF BUSINESS OR INDUSTRY - - - - -		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>							
13. FATHER'S NAME <u>Benjamin Thomas</u>				14. MOTHER'S MAIDEN NAME <u>Elizabeth Johnson</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>?</u>				16. SOCIAL SECURITY NO. <u>?</u>			
17. INFORMANT <u>Hospital Records</u>				Address <u>Crownsville, Maryland</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Congestive Heart Failure</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Arteriosclerotic Cardiovascular Disease</u> DUE TO (c) <u>Malnutrition</u>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)							
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>			
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)				20f. (City or town) (County) (State)			
21. I certify that I attended the deceased from <u>July 1, 1957</u> to <u>August 20, 1957</u> , that I last saw the deceased alive on <u>August 20, 1957</u> , and that death occurred at <u>6:25 a.m.</u> from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED <u>Conwell Newton, M.D.</u> <u>Crownsville, Maryland</u> <u>8-21-57</u>							
ACTUAL SIGNATURE							
PHYSICIAN'S NAME (Type) <u>Conwell Newton, M.D.</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Removal 8-27-57</u>				22b. DATE THEREOF			
22c. NAME OF CEMETERY OR CREMATORY <u>University of Md.</u>				22d. LOCATION (City, town, or county) (State) <u>Balt. Md.</u>			
23. FUNERAL DIRECTOR'S SIGNATURE <u>William Kessett</u>				24a. REC'D BY REGISTRAR DATE <u>8/29/57</u>			
ADDRESS <u>108 Wash. St.</u>				24b. REGISTRAR'S SIGNATURE <u>H. M. Jones</u>			

RECEIVED
AUG 29 1957
BUREAU V. 2

08219

CERTIFICATE OF DEATH

08214

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY AA MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MD b. COUNTY AA	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) WEEMS CREEK		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) WEEMS CREEK	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION MEYETT ROAD		d. STREET ADDRESS MEYETT ROAD	
3. NAME OF DECEASED (Type or print) ELIZABETH VIRGINIA TAYMAN THOMAS		4. DATE OF DEATH Month 8 - Day 5 - Year 1957	
5. SEX FEMALE	6. COLOR OR RACE WHITE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 7-28-1877
9. AGE (In years last birthday) 80 yrs		10. IF UNDER 1 YEAR, IF UNDER 24 HRS Months _____ Days _____ Hours _____ Min. _____	
10a. USUAL OCCUPATION (Give kind of work done during most of working life; even if retired) HOUSE WIFE		10b. KIND OF BUSINESS OR INDUSTRY HOME	
11. BIRTHPLACE (State or foreign country) PRI. GEO. Co. MD		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME JAMES TAYMAN		14. MOTHER'S MAIDEN NAME Unknown	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) -		16. SOCIAL SECURITY NO. -	
17. INFORMANT Miss Ruth Thomas		Address (2)	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Cerebral Hemorrhage SEX DUE TO (b) Artificial Hypertension Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) Arterio Sclerosis		INTERVAL BETWEEN ONSET AND DEATH 2 1/2 hrs	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. _____ p. m. _____ 19 _____		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 2-4 , 19 57 , to 8-5 , 19 57 , that I last saw the deceased alive on 8-4 , 19 57 , and that death occurred at 2:17 M, from the causes and on the date stated above.			
ACTUAL SIGNATURE J. Oliver Purvis M.D.		ADDRESS (Street, city or town, state) DATE SIGNED Annapolis, Md. 8/6/57	
PHYSICIAN'S NAME (Type) J. Oliver Purvis		Annapolis, Maryland	
22a. BURIAL, CREMATION, REMOVAL (Specify)	22b. DATE THEREOF 8-8-57	22c. NAME OF CEMETERY OR CREMATORY ST MARYS CEMT	22d. LOCATION (City, town, or county) (State) ANNAPOLIS MD
23. FUNERAL DIRECTOR'S SIGNATURE John M. Saylor, Son		ADDRESS Annapolis, Md.	
24a. REC'D BY REGISTRAR 8/7/57		24b. REGISTRAR'S SIGNATURE	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 & 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

RECEIVED

AUG 8 1957

BUREAU V. S.

08162

CERTIFICATE OF DEATH

08215 21

Reg. Dist. No.

1 PLACE OF DEATH a. COUNTY <u>Anne Arundel</u> MARYLAND		2 USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Anne Arundel</u>	
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Annapolis</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Annapolis</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) <u>3531 Washington St.</u>		d. STREET ADDRESS <u>3531 Washington St.</u>	
3. NAME OF DECEASED (Type or print) <u>Pattie Thorne</u>		4. DATE OF DEATH Month <u>8</u> Day <u>31</u> Year <u>1957</u>	
5 SEX <u>Female</u>	6. COLOR OR RACE <u>Col.</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>9-10-1890</u>
9. AGE (In years last birthday) <u>66</u> yrs		10. IF UNDER 1 YEAR IF UNDER 24 HRS Months <u>6</u> Days <u>21</u> Hours <u>15</u> Min <u>00</u>	
10a. USUAL OCCUPATION (Give kind of work done during last working life, even if retired) <u>Domestic</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>North Carolina U.S.A.</u>	
11. BIRTHPLACE (State or foreign country) <u>North Carolina U.S.A.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Robert Young</u>		14. MOTHER'S MAIDEN NAME <u>Rebecca Hollaway</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or date of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>1-1-1-1-1-1-1-1-1-1</u>	
17. INFORMANT <u>Coira Knight - Annapolis, Md.</u>		Address <u>Annapolis, Md.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH CAUSED BY IMMEDIATE CAUSE (a) <u>174x</u> DUE TO <u>Exhaustion of Uterus</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>1951-1957</u> (c)			INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <u>2/5</u> , 19 <u>51</u> , to <u>8/31</u> , 19 <u>57</u> , that I last saw the deceased alive on <u>8/31</u> , 19 <u>57</u> , and that death occurred at <u>1:30</u> A.M., from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Theodore H. Johnson</u> M.D.		ADDRESS (Street, city or town, state) <u>37 Calvert Street, Annapolis, Md.</u> DATE SIGNED <u>9/3/57</u>	
22a. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>9-4-57</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>St. Johns</u>		22d. LOCATION (City, town, or county) (State) <u>Annapolis, Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>William Reese</u> ADDRESS <u>Annapolis, Md.</u>		24a. REC'D BY REGISTRAR <u>1957</u> 24b. REGISTRAR'S SIGNATURE <u>Wm. French</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

(1) (2) (3) (4) (5) (6) (7) (8) (9) (10) (11) (12) (13) (14) (15) (16) (17) (18) (19) (20) (21) (22) (23) (24) (25) (26) (27) (28) (29) (30) (31) (32) (33) (34) (35) (36) (37) (38) (39) (40) (41) (42) (43) (44) (45) (46) (47) (48) (49) (50) (51) (52) (53) (54) (55) (56) (57) (58) (59) (60) (61) (62) (63) (64) (65) (66) (67) (68) (69) (70) (71) (72) (73) (74) (75) (76) (77) (78) (79) (80) (81) (82) (83) (84) (85) (86) (87) (88) (89) (90) (91) (92) (93) (94) (95) (96) (97) (98) (99) (100)

1957 6 2

RECEIVED

1957 6 2

08163

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Anne Arundel</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Anne Arundel</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Annapolis</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Cape Loch Haven</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Anne Arundel General Hospital</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <u>FERN D.</u> Middle <u>KYLE</u> Last <u>TOLSON</u>				4. DATE OF DEATH Month <u>August</u> Day <u>4</u> Year <u>1957</u>			
5. SEX <u>Female</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>Nov 21, 1889</u>	
9. AGE (In years last birthday) <u>67</u> yrs		IF UNDER 1 YEAR Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u>		IF UNDER 24 HRS Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even, if retired) <u>Homemaker</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>Fort Wayne, Indiana U.S.</u>			
11. BIRTHPLACE (State or foreign country) <u>Fort Wayne, Indiana U.S.</u>				12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>			
13. FATHER'S NAME <u>William Kyle</u>				14. MOTHER'S MAIDEN NAME <u>Unknown</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>				16. SOCIAL SECURITY NO. <u>none</u>			
17. INFORMANT <u>Frank F. Tolson</u>				Address <u>Edgewater, Md.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Congestive heart failure</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Chronic heart disease</u> DUE TO (c) <u> </u>							INTERVAL BETWEEN ONSET AND DEATH <u>2 weeks</u> <u>10 years</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour <u> </u> a. m. <u> </u> p. m. <u> </u> 19 <u> </u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town)				20g. (County)		20h. (State)	
21. I certify that I attended the deceased from <u>August 1, 1957</u> , to <u>August 4, 1957</u> , that I last saw the deceased alive on <u>August 4, 9:30 P.M. 1957</u> , and that death occurred at <u>9:30 P.M.</u> from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>Richard N. Peeler</u> M.D. <u>Franklin St. Annapolis, Md.</u>				ADDRESS (Street, city or town, state)			
DATE SIGNED <u>August 7, 1957</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify)				22b. DATE THEREOF		22c. NAME OF CEMETERY OR CREMATORY	
<u>Burial</u>				<u>Aug 7, 57</u>		<u>Washington, Natl</u>	
22d. LOCATION (City, town, or county)				22e. (State)			
<u>Suitland, Maryland</u>				<u>Maryland</u>			
23. FUNERAL DIRECTOR'S SIGNATURE <u>W. W. Chambers at Washington DC</u>				ADDRESS <u>Washington DC</u>		24a. REC'D BY REGISTRAR DATE <u>AUG 7 1957</u>	
24b. REGISTRAR'S SIGNATURE <u>Wm. J. Sanchez</u>				24c. (City or town)		24d. (State)	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

RECEIVED

JUG 7 1957

BUREAU V. S.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
 15M 9/55

Dr. Beck

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

08217

08164

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>A.A. Co. ru del</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>A.A. Co.</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Annapolis</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rt. #1 Edgewater Md.</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>A.A. General</u>				d. STREET ADDRESS <u>Rt. 1 Box 180</u>			
3. NAME OF DECEASED (Type or print) First <u>HAROLD</u> Middle <u>A.</u> Last <u>TRAFTON</u>				4. DATE OF DEATH Month <u>8</u> Day <u>31</u> Year <u>1957</u>			
5. SEX <u>Male</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>6/26/1890</u>	
9. AGE (In years last birthday) <u>67</u> yrs		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Electrical Engineer</u>		11. BIRTHPLACE (State or foreign country) <u>Mass.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Lorenzo George Trafton</u>				14. MOTHER'S MAIDEN NAME <u>Clara I. Gilcrease</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>Yes</u>		16. SOCIAL SECURITY NO. (If yes, give year or dates of service) <u>1917-1919</u>		17. INFORMANT <u>Evelyn Trafton #2</u> Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Melanotic Carcinoma</u> <u>144X</u> DUE TO <u>CARCINOMA OF BRONCHIAL MUCOSA</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>1 YEAR</u> DUE TO (c)						INTERVAL BETWEEN ONSET AND DEATH <u>6 MONTHS</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>8/5, 1957</u> to <u>8/31, 1957</u> , that I last saw the deceased alive on <u>8/31, 1957</u> , and that death occurred at <u>3:30 PM</u> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) <u>9/3/57</u> ACTUAL SIGNATURE <u>Edward H. Beck</u> M.D. DATE SIGNED <u>9/3/57</u> PHYSICIAN'S NAME (Type)							
22a. BURIAL, CREMATION, REMOVAL, ETC. (Specify) <u>Burial</u>		22b. DATE THEREOF <u>9/4/57</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Arlington Nat'l.</u>		22d. LOCATION (City, town, or county) (State) <u>Arlington Va.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>John M. Taylor and Sons</u> ADDRESS <u>Annapolis, Md.</u>				24a. REC'D BY REGISTRAR <u>9/4/57</u>		24b. REGISTRAR'S SIGNATURE <u>[Signature]</u>	

BUREAU V. E.

1957

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

08218

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>A.A. CO</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>DELETED D.C.</u> b. COUNTY _____			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>DAVIDSON</u>		c. LENGTH OF STAY IN 1b _____		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <input checked="" type="checkbox"/> <u>Washington</u>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) _____				d. STREET ADDRESS <u>(803 Aspen St., N.W.)</u> <u>ASPEN + 4th St. N.W.</u>			
3. NAME OF DECEASED (Type or print) First <u>Richard.</u> Middle <u>H.</u> Last <u>Jr. Trotter</u>				4. DATE OF DEATH Month <u>8</u> Day <u>17</u> Year <u>1957</u>			
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>4/27/1940</u>	9. AGE (In years last birthday) <u>17</u> yrs.	IF UNDER 1 YEAR Months _____ Days _____		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Refrigeration ---</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Assistant</u>		11. BIRTHPLACE (State or foreign country) <u>Washington, D.C.</u>			
13. FATHER'S NAME <u>Richard H. Trotter, Sr.</u>				14. MOTHER'S MAIDEN NAME <u>Rebecca Nicholson</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>578-52-8312</u>		17. INFORMANT Address <u>Richard H. Trotter, Sr. - 803 Aspen St., N.W.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Compd. Fracture. Skull</u> X DUE TO _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO _____ (c) _____							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____							
20a. EXTERNAL CAUSE WAS PRIMARY OR CONTRIBUTING CAUSE OF DEATH. <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>Auto Accidental R.F. #2</u>					
20c. TIME OF INJURY Month, Day, Year Hour <u>5-17</u> 19 <u>57</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>Highway</u>			
20f. (City or town) <u>A.A. CO.</u>		(County) _____ (State) _____					
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/>, Inspection <input checked="" type="checkbox"/>, Inquiry <input type="checkbox"/>, and find that death resulted from: Natural causes <input type="checkbox"/> , Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .							
ACTUAL SIGNATURE <u>E. Linhardt</u>		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>		DATE SIGNED <u>8-17-57</u>			
EXAMINER'S NAME (Type) <u>E. Linhardt</u>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>8/20/1957</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Prince Lincoln Cemetery</u>			
22d. LOCATION (City, town, or county) (State) <u>Prince Georges County, Md.</u>		23. FUNERAL DIRECTOR'S SIGNATURE <u>The S. H. Hines Co. - 2901 14th St. N.W.</u> <u>Washington 9, D.C.</u>					
24a. REC'D BY REGISTRAR <u>AUG 20 57</u>		24b. REGISTRAR'S SIGNATURE <u>DeLoach</u>					

DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please enclose the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

BUREAU V. 2

AUG 29 1957

RECEIVED

08221

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Anne Arundel</u> <u>MARYLAND</u>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>District of Columbia</u> b. COUNTY <u>Prince George's</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Crownsville</u>				c. LENGTH OF STAY IN 1b <u>2yrs. 4mo. 6days</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Crownsville State</u>				d. STREET ADDRESS <u>5806 Sheriff Rd.</u>			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First <u>Verg</u> Middle <u>Twitty</u> Last <u>Twitty</u>				4. DATE OF DEATH Month <u>8-25-</u> Day <u>19</u> Year <u>57</u>			
5. SEX <u>Male</u>	6. COLOR OR RACE <u>Negro</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>?</u>	9. AGE (In years last birthday) <u>76</u> yrs.	IF UNDER 1 YEAR Months <u>76</u> Days <u>?</u> Hours <u>?</u> Min <u>?</u>	IF UNDER 24 HRS. Months <u>?</u> Days <u>?</u> Hours <u>?</u> Min <u>?</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Farmer</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>---</u>		11. BIRTHPLACE (State or foreign country) <u>South Carolina</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Wash Twitty</u>				14. MOTHER'S MAIDEN NAME <u>Adeline Twitty</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>---</u>		16. SOCIAL SECURITY NO. <u>---</u>		17. INFORMANT Address <u>Hospital Records Crownsville, Maryland</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral Vascular Accident</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Generalized Arteriosclerosis</u> DUE TO (c) <u>---</u>							INTERVAL BETWEEN ONSET AND DEATH <u>---</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>---</u>					
20c. TIME OF INJURY Month, Day, Year Hour <u>a. m.</u> <u>19</u> p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>---</u>		20f. (City or town) (County) (State) <u>---</u>	
21. I certify that I attended the deceased from <u>8-6-</u> , 19 <u>57</u> , to <u>8-25-</u> , 19 <u>57</u> , that I last saw the deceased alive on <u>8-25-</u> , 19 <u>57</u> , and that death occurred at <u>3:10 p. M.</u> from the causes and on the date stated above ADDRESS (Street, city or town, state) <u>Crownsville, Maryland</u> DATE SIGNED <u>8-26-57</u>							
ACTUAL SIGNATURE <u>Conwell Newton, M.D.</u> M.D. <u>Crownsville, Maryland</u>							
PHYSICIAN'S NAME (Type) <u>Conwell Newton, M. D.</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>8/29/57</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Pleasant Grove</u>		22d. LOCATION (City, town or county) (State) <u>Lanester S.C.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Ambrose B. Boyd</u>				ADDRESS <u>1238-20th St. N.W.</u>		24a. REC'D BY REGISTRAR DATE <u>8-26-57</u>	
				24b. REGISTRAR'S SIGNATURE <u>H. M. Jager</u>			

BUREAU V. S.

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RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/55

08222 MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

Item 14, File 3219, 8/23/57

Reg. Dist. No.

08220 74

1. PLACE OF DEATH a. COUNTY <u>ANN ARUNDIEL</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>ANN ARUNDIEL</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Glen Burnie</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Glen Burnie</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) <u>#307-1st Ave. S.W.</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>Viola Wolf Volkhard</u>		4. DATE OF DEATH <u>August 9 1957</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>MAY 28 1897</u>
9. AGE (In years last birthday) <u>60</u>		10. IF UNDER 1 YEAR IF UNDER 24 HRS	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Same</u>	
11. BIRTHPLACE (State or foreign country) <u>Pennsylvania</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>William Wolf</u>		14. MOTHER'S MAIDEN NAME <u>Mary Pierce</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>—</u>	
17. INFORMANT <u>Robert Volkhard - Glen Burnie S.W.</u>		Address <u>#307 1st Ave S.W.</u>	
18. CAUSE OF DEATH [Enter only one cause per line in (a), (b) and (c)]			INTERVAL BETWEEN ONSET AND DEATH
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Pulmonary Edema</u>			<u>3 min</u>
DUE TO <u>Congestive Heart Failure</u>			<u>4 yrs.</u>
DUE TO <u>Coronary Artery Disease</u>			<u>10 yrs</u>
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Hypertension, Arterial Essential</u>			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <u>5/10 1950</u> to <u>8/9 1957</u> that I last saw the deceased alive on <u>8/9 1957</u> and that death occurred at <u>6:30 P.M.</u> from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>R.W. Prichard</u> M.D.		DATE SIGNED <u>8/9/57</u>	
PHYSICIAN'S NAME (Type) <u>R.W. PRICHARD M.D.</u>		ADDRESS (Street, city or town, state) <u>715 Colter Rd Glen Burnie Md</u>	
22a. BURIAL CREMATION REMOVAL (Specify)	22b. DATE THEREOF <u>August 12, 1957</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Chesler Funeral Cemetery</u>	22d. LOCATION (City, town, or county) (State) <u>Chesler, Pennsylvania</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>R. Singleton</u>		24a. REC'D BY REGISTRAR <u>John D. Kelley</u>	
ADDRESS <u>Glen Burnie, Md.</u>		24b. REGISTRAR'S SIGNATURE <u>John D. Kelley</u>	
DATE <u>AUG 15 1957</u>			

MEDICAL CERTIFICATION

RECEIVED

AUG 15 1957

BUREAU V. S.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 1 may be retained by the hospital or attending physician. The funeral director should be filed with page 3. The funeral director should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

Items 1,9

08223

CERTIFICATE OF DEATH

08221

Reg. Dist. No.

24

1. PLACE OF DEATH a. COUNTY <u>Anne Arundel</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Balto.</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Pasadena</u>	c. LENGTH OF STAY IN TB <u>1 month</u>	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Woodlawn, Md. (Balto P.C.)</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>North Shore (Private home)</u>		d. STREET ADDRESS <u>2413 Birch Drive</u>	
3. NAME OF DECEASED (Type or print) First <u>Cora</u> Middle <u>Robinson</u> Last <u>Warner</u>		4. DATE OF DEATH Month <u>Aug</u> Day <u>2</u> Year <u>1957</u>	
5. SEX <u>F</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Feb 9 1878</u>
9. AGE (In years last birthday) <u>79</u> yrs.		10. IF UNDER 1 YEAR IF UNDER 24 HRS Months <u>2</u> Days <u>19</u> Hours <u>57</u> Min	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Balto. city</u>	
11. BIRTHPLACE (State or foreign country) <u>USA</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>LOGAN NELSON ROBINSON</u>		14. MOTHER'S MAIDEN NAME <u>TINA STIFF</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>		16. SOCIAL SECURITY NO. <u>unknown</u>	
17. INFORMANT <u>Elizabeth Toler Warner</u>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>myocardial failure</u> <u>450.0</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) <u>senility (Arteriosclerosis)</u> DUE TO (c) <u>Cachexia</u>		INTERVAL BETWEEN ONSET AND DEATH <u>unknown</u> <u>4 months</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour <u>a. m.</u> <u>19</u> p. m.		20d. INJURY OCCURRED While <input type="checkbox"/> at work <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>Aug 2</u> , 19 <u>57</u> , to <u>Aug 2</u> , 19 <u>57</u> , that I last saw the deceased alive on <u>Aug 2</u> , 19 <u>57</u> , and that death occurred at <u>2:00 PM</u> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED			
ACTUAL SIGNATURE <u>Arthur Lankford Jr</u> M.D.			
PHYSICIAN'S NAME (Type) <u>ARTHUR LANKFORD JR MOUNTAIN RD. PASADENA MD.</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>8-6-57</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Louisa Park Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Baltimore, Maryland</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Ellsworth Armacost</u>		24. PREC'D BY REGISTRAR <u>1957</u>	
24b. REGISTRAR'S SIGNATURE <u>K. J. Seabey</u>			

BUREAU V. S.

RECEIVED
JUL 10 1900

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

08165

CERTIFICATE OF DEATH

08222 21
Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Anne Arundel L.</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Md.</u> b. COUNTY <u>AA</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Annapolis Md</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Pasadena Md</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OF INSTITUTION <u>Anne Arundel Gen Hosp.</u>		d. STREET ADDRESS <u>Pasadena Rd.</u>	
3. NAME OF DECEASED (Type or print) <u>Preston</u> First <u>ELNathen</u> Middle <u>Watts</u> Last		4. DATE OF DEATH <u>8-28-57</u> Month <u>8</u> Day <u>28</u> Year <u>19</u>	
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>8-27-1899</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Shovel Operator State Roads</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Glen Burnie</u>	
13. FATHER'S NAME <u>William Theodore Watts</u>		14. MOTHER'S MAIDEN NAME <u>LYDIA Stuchcomb</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>		16. SOCIAL SECURITY NO. <u>212-18-419</u>	
17. INFORMANT <u>Wife</u> Mrs Watts. <u>Pasadena Md.</u>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Congestive Heart Failure</u> <u>416 X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Myocardial Infarction</u> (c) <u>Rheumatic Heart Disease</u>			INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. 31. p. m. <u>19</u>	20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <u>8-24-57</u> , 19 <u>57</u> , to <u>8-28-57</u> , 19 <u>57</u> , that I last saw the deceased alive on <u>8-22-57</u> , 19 <u>57</u> , and that death occurred at <u>5:40 AM</u> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Robert R. Hahn</u> M.D.		ADDRESS (Street, city or town, state) <u>Severna Park Md</u> DATE SIGNED <u>8-28-57</u>	
PHYSICIAN'S NAME (Type) <u>Robert R Hahn</u>		<u>Md</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>Aug. 31, 1957</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Glen Haven Memorial</u>	22d. LOCATION (City, town, or county) (State) <u>Glen Burnie, Md.</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>Hopping & Kirkley</u> ADDRESS <u>Glen Burnie, Md.</u>		24a. REC'D BY REGISTRAR <u>SEP 3 1957</u> REGISTRAR'S SIGNATURE <u>John J. Stuchcomb</u>	

7 A OVERALL

2001 0 0

03 A1525

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please enclose the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your records. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

VS. A15ME(3)
SM 9/55

08166

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

08223

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>A.A.CO.</u> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>ANNAPOLIS</u> c. LENGTH OF STAY IN 1b d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>H.A. GOWER Hospital</u>		2. USUAL RESIDENCE (Where deceased lived. If Institution: Residence before admission) a. STATE <u>MD.</u> b. COUNTY <u>H.H.</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>DAVIDSONVILLE, MD.</u> d. STREET ADDRESS e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF (Type or print) <u>Susie MAE WILLIAMS</u>		4. DATE OF DEATH Month <u>8</u> Day <u>1</u> Year <u>1957</u>	
5. SEX <u>F</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>1894 11-9-1893</u>
9. AGE (in years last birthday) <u>63 yrs.</u>		IF UNDER 1 YEAR Months <u>0</u> Days <u>0</u>	IF UNDER 24 HRS. Hours <u>0</u> Min. <u>0</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>HOUSEWIFE</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>HOME</u>	
11. BIRTHPLACE (State or foreign country) <u>GEORGIA</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>	
13. FATHER'S NAME <u>GEORGE BOWMAN</u>		14. MOTHER'S MAIDEN NAME <u>BAMAH TARYSLEY</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>—</u>		16. SOCIAL SECURITY NO. <u>—</u>	
17. INFORMANT <u>MRS. HENRY NOWOTNICK</u>		Address <u>#2</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Heart disease</u> <u>434.3</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>—</u> DUE TO (c) <u>—</u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>—</u>			
INTERVAL BETWEEN ONSET AND DEATH <u>Instant</u>			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year <u>19</u> Hour <u>—</u> o. m. <u>—</u> p. m. <u>—</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and find that death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/> . ACTUAL SIGNATURE <u>E. Linhardt</u> M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> EXAMINER'S NAME (Type) <u>E. Linhardt</u> DATE SIGNED <u>8/1/57</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		22b. DATE THEREOF <u>8-3-57</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>HILLCREST</u>		22d. LOCATION (City, town, or county) (State) <u>ANNAPOLIS, MD.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Mr. M. Taylor + Mrs. Annapolis, Md</u>		24a. REC'D BY REGISTRAR <u>—</u> 24b. REGISTRAR'S SIGNATURE <u>—</u>	
DATE <u>8/2/57</u>		<u>—</u>	

BUREAU V. S.

AUG 5 1957

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

08224
34

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Anne Arundel MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Anne Arundel			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Glen Burnie		c. LENGTH OF STAY IN 15 3 hours.		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Glen Burnie X			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Drifwood Tavern				d. STREET ADDRESS Wellham Ave. and Wilson Lane		e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Frank James Middle Witkowski Last 				4. DATE OF DEATH Month August Day 1st. Year 1957			
5. SEX M	6. COLOR OR RACE W.	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 3/23/03		9. AGE (In years last birthday) 54 yrs	IF UNDER 1 YEAR Months Days 	IF UNDER 24 HRS. Hours Min
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Poultry Farm		10b. KIND OF BUSINESS OR INDUSTRY 		11. BIRTHPLACE (State or foreign country) Baltimore Md.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Steven Witkowski				14. MOTHER'S MAIDEN NAME Josephine Cichocki			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. 218-32-2545		17. INFORMANT Address Miss. Agnes B. Witkowski (sister)			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary Occlusion 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (b) (c), stating the underlying cause lost. DUE TO (c) 						INTERVAL BETWEEN ONSET AND DEATH Sudden	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 							
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month Day Year 19 Hour a. m. p. m. 	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)		
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> and find that death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .							
ACTUAL SIGNATURE: <i>Gustave H. Faubert</i> M.D.				CHIEF MEDICAL EXAMINER <input type="checkbox"/>		DATE SIGNED	
EXAMINER'S NAME (Type) Gustave H. Faubert, M.D.				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> 8/1/57 8/1/57			
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		22b. DATE THEREOF AUG 5, 1957		22c. NAME OF CEMETERY OR CREMATORY HOLY ROSARY		22d. LOCATION (City, town, or county) (State) 7335 GERMAN Hill Rd	
23. FUNERAL DIRECTOR'S SIGNATURE <i>George A. Weber</i>				ADDRESS 705 S. Ann st		24. PREPARED BY REGISTRAR 8/1/57 25. REGISTRAR'S SIGNATURE <i>L. J. Kelly</i>	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please indicate the cause of the delay in the space provided. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be retained by the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation or removal.

U. S. V. 40

16

RECEIVED

08225

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Anne Arundel MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Crownsville				c. LENGTH OF STAY IN 1b 9yrs. 8mo. 30da.			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Crownsville State				d. STREET ADDRESS 1700 Latrobe Street			
3. NAME OF DECEASED (Type or print) First John Middle Witlock Last (Whitlock)				4. DATE OF DEATH Month 8 Day 31- Year 1957			
5. SEX male	6. COLOR OR RACE Negro	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH unknown	9. AGE (In years last birthday) 60? yrs.	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS. Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) unknown		10b. KIND OF BUSINESS OR INDUSTRY - - - - -		11. BIRTHPLACE (State or foreign country) unknown		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME unknown				14. MOTHER'S MAIDEN NAME Lizzie Smith			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) - - - - -		16. SOCIAL SECURITY NO. - - - - -		17. INFORMANT Address Hospital Records Crownsville, Maryland			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Heart Failure 420.0 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Arteriosclerotic Heart Disease DUE TO (c)							INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Malnutrition and Dehydration							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work of work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)		
21. I certify that I attended the deceased from July 1, 19 57, to August 31, 19 57, that I last saw the deceased alive on 8-31- 19 57 and that death occurred at 6:20 A.M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED ACTUAL SIGNATURE Lionel McHenry Mapp, M.D. Crownsville, Maryland 9-3-57 PHYSICIAN'S NAME (Type) Lionel McHenry Mapp, M.D.							
22a. BURIAL, CREMATION, REMOVAL (Specify)		22b. DATE THEREOF	22c. NAME OF CEMETERY OR CREMATORY		22d. LOCATION (City, town, or county) (State)		
SEPT-7-1957		St. Calvary Cem.		Qaco		MD	
23. FUNERAL DIRECTOR'S SIGNATURE Rayner Sanders			ADDRESS 217 E. Preston St. Baltimore		24a. REC'D BY REGISTRAR DATE 9/6/57	24b. REGISTRAR'S SIGNATURE St. M. Joyce	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 1 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3, should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

BUREAU V. S.

SEP 9 1907

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THIS MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please enclose the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

VS. A15ME(5)
5M 9/55

08226

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

08226

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Anne Arundel</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution; residence before admission) a. STATE <u>Same</u> b. COUNTY <u>Same</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Linthicum</u>		c. LENGTH OF STAY IN 1b <u>2 months</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Same</u>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>305 Regency Circle</u>				d. STREET ADDRESS <u>Same</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME DECEASED (Type or print) First <u>Broadus</u> Middle <u>Lee</u> Last <u>Wood</u>				4. DATE OF DEATH Month <u>August</u> Day <u>9</u> Year <u>1957</u>			
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>8/22/93</u>	9. AGE (In years and birthday) <u>63</u> yrs.	IF UNDER 1 YEAR Months <u></u> Days <u></u>	IF UNDER 24 HRS Hours <u></u> Min. <u></u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired leather roller</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>LEATHER</u>		11. BIRTHPLACE (State or foreign country) <u>Boonesville, Va.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Robert Lee Wood</u>				14. MOTHER'S MAIDEN NAME <u>Florence Hall</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>YES</u>		16. SOCIAL SECURITY NO. <u>W.W.I.</u> <u>235-05-3251</u>		17. INFORMANT <u>Earl Wood (son)</u>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Multiple fractures of skull due to self</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>inflicted wound with a 12 gauge shot gun.</u> DUE TO (c) <u></u>						INTERVAL BETWEEN ONSET AND DEATH <u>Sudden</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. EXTERNAL CAUSE WAS PRIMARY OR CONTRIBUTING CAUSE OF DEATH. <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18) <u>See #18</u>					
20c. TIME OF INJURY Month, Day, Year <u>4:30</u> a.m. <u>8/9/57</u> 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>Home</u>		20f. (City or town) (County) (State) <u>Linthicum</u> <u>A.A.</u> <u>Md.</u>	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , inspection <input checked="" type="checkbox"/> , inquiry <input checked="" type="checkbox"/> , and find that death resulted from: Natural causes <input type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input checked="" type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .							
ACTUAL SIGNATURE <u>Gustave H. Faubert</u>				M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>		DATE SIGNED	
EXAMINER'S NAME (Type) <u>Gustave H. Faubert, M.D.</u>				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		<u>8/9/57 8/9/57</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		22b. DATE THEREOF <u>Aug 11, 1957</u>		22c. NAME OF CEMETERY OR CREMATORY <u>PRIZE HILL</u>		22d. LOCATION (City, town, or county) (State) <u>BOONESVILLE, VA.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>George J. Gonce</u>				ADDRESS <u>4001 Ritchie Hwy</u>		24a. REC'D BY REGISTRAR <u>Aug 15 '57</u>	
				24b. REGISTRAR'S SIGNATURE <u>Overhach</u>			

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AUG 15 1957
BUREAU V. S.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

08167

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Anne Arundel</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Anne Arundel</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Annapolis, Md.</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>10 Annapolis</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>U.S. Naval Hospital</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Percy</u> Middle <u>Lee</u> Last <u>WOOD</u>		4. DATE OF DEATH Month <u>August</u> Day <u>6</u> Year <u>1957</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>Caucasian</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>11 June 1888</u>
9. AGE (In years last birthday) <u>69</u> yrs.		10. IF UNDER 1 YEAR: IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Carpenter</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Home Bldg.</u>	
11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>	
13. FATHER'S NAME <u>Benjamin F. WOOD</u>		14. MOTHER'S MAIDEN NAME <u>Annie BOWEN</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>214-12-4707</u>	
17. INFORMANT <u>U.S. Naval Hospital, Annapolis, Md.</u>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Pulmonary Embolism, Massive</u> <u>420.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Mural Thrombi, right ventricular</u> DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>5 August</u> , 19 <u>57</u> , to <u>6 August</u> , 19 <u>57</u> , that I last saw the deceased alive on <u>6 August</u> , 19 <u>57</u> , and that death occurred at <u>6:50 A.M.</u> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED			
ACTUAL SIGNATURE <u>[Signature]</u> M.D. <u>U.S. Naval Hospital, Annapolis, Md.</u> 8-7-57			
PHYSICIAN'S NAME (Type) <u>D. R. BAHNER, LT. MC, USNR</u>			
22a. BURIAL-CREATION, REMOVAL (Specify) <u>burial</u>	22b. DATE THEREOF <u>8-9-57</u>	22c. NAME OF CEMETERY OR CREMATORY <u>St Marys Cem</u>	22d. LOCATION (City, town, or county) (State) <u>Annapolis Md.</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>John W. Saylor Sons</u>		24a. REC'D BY REGISTRAR DATE <u>8/7/57</u>	
ADDRESS <u>Annapolis Md</u>		24b. REGISTRAR'S SIGNATURE <u>[Signature]</u>	

CERTIFICATE OF DEATH

BUREAU V. S.

AUG 8 1957

RECEIVED

CERTIFICATE OF DEATH

MASSACHUSETTS DEPARTMENT OF HEALTH - BOSTON

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JUN 12 1957
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